

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☒ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

June 17, 2003

ALL-COUNTY INFORMATION NOTICE NO.: I-36-03

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IHSS PROGRAM MANAGERS

**SUBJECT: CONTINUED IMPLEMENTATION OF THE TYLER V. ANDERSON
JUDGMENT IN THE IN-HOME SUPPORTIVE SERVICES (IHSS)
PROGRAM**

REFERENCES: ALL-COUNTY LETTER 08-01
ALL-COUNTY INFORMATION NOTICE NO. 1-01-01
ALL COUNTY INFORMATION NOTICE NO. 1-121-00
ALL COUNTY INFORMATION NOTICE NO. 1-99-99

The purpose of this ALL-County Information Notice (ACIN) is to provide counties with an update regarding the continued efforts of the Disability and Adult Programs Division, Tyler Unit, to ensure that all Tyler v. Anderson claimants receive notices informing them of their possible eligibility for potential Tyler benefits.

The Sacramento County Superior Court approved the Tyler v. Anderson settlement agreement in a judgment on January 22, 1999. In accordance with this judgment, the California Department of Social Services will attempt to update the addresses of approximately 170,000 individuals whose original Tyler notices were returned by the United States (US) Postal Service. Notices are expected to be mailed on June 25, 2003. The claiming period begins July 1, 2003 and ends December 31, 2003.

Tyler Class Members

The class members remain the same. The class includes recipients, applicants, and providers of In-Home Supportive Services (IHSS) who were denied payment for Range of Motion (ROM) exercises from June 17, 1990 through March 31, 1994.

Excluded Counties

Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama counties are still excluded from the settlement as they continued to provide ROM services during the period June 17, 1990 through March 31, 1994.

Tyler Claim Forms, Notices and Posters

Counties **will not** be required to display the Tyler poster nor give a Tyler claim form or Tyler Notice to anyone who calls the county directly. However, counties will be required to log the name and telephone numbers of anyone who contacts them requesting a notice and claim form. A telephone log form is attached for the counties to use for logging in Tyler calls. The Tyler logs containing the names and telephone numbers must be sent via fax, telephone or email to tlawsuit@dss.ca.gov. The county shall also refer the individual directly to the Tyler Unit. The Tyler Unit toll-free telephone numbers are listed below:

Tyler Unit Toll-Free Number:	1-877-508-1327
Tyler Unit Fax:	1-877-508-1328

Class Member Mailing

The Tyler Notice and Claim Form will be mailed in English and Spanish to approximately 75,000 class members whose notices were returned by the U.S. Post Office and for whom we received a new updated address. These are the same IHSS recipients and providers who were on the Case Management, Information, and Payrolling System from June 1990 through March 1994.

Claim Period and Filing a Claim

The claim filing period begins July 1, 2003 and ends on December 31, 2003. The counties are required to advise anyone who contacts them regarding the final filing date to file their claim with the California Department of Social Services, Tyler Unit at 744 P Street, M.S. 19-04, Sacramento, California 95814, even if the final filing date has passed. The Tyler Unit will be conducting a special review of all late claims. If a claimant has questions or needs assistance with completing the claim form they should call the toll free number 1-877-508-1327.

County Fiscal Claiming

Information on fiscal claiming for Tyler v. Anderson was provided in County Fiscal Letter (CFL) 00/01-48 dated December 22, 2000. The administrative activities related to the judgment such as the anticipated telephone calls and the referrals to the Tyler Unit will be reported to Time Study Code 1042, IHSS – NON-HR/NON-PCSP. A copy of the CFL 00/01-48 is attached.

County Training and Requirements

Since the information that was provided to the counties as a result of the original mail-out is the same for this mail out, the Tyler Unit will not provide additional training to the counties. If questions arise as a result of telephone calls from claimants, the county can utilize the toll free number 1-877-508-1327 to contact Tyler staff or call Ardora McCalley, Tyler Analyst, at (916)-229-4044.

Counties are required to retain all IHSS case files from January 1989 to current.

(Counties are also cautioned not to destroy records from April 1979 to November 1988 for the purposes of the Miller v. Woods I, II and the Welfare Rights Organization (WRO) v. McMahon judgements.)

If you have any questions related to this ACIN, please contact Ardora McCalley, Tyler Analyst, at (916) 229-4044 or Patricia Johnston, Chief at (916) 229-4000.

Sincerely,

***Original Document
Signed By***

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachments

TYLER V. ANDERSON CLAIMANT
COUNTY TELEPHONE LOG

NAME	TELEPHONE NUMBERS * (HOME , CELL ETC.)	Language (English, Spanish, etc.)

TYLER UNIT 1-877-508-1327
 TYLER UNIT FAX 1-877-508-1328

*If claimant is not reachable by telephone, please obtain an address and place it in the telephone number column.

TYLER NOTICE

THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY

The State of California did not pay for "Range of Motion" services for the aged, blind or disabled people in the IHSS Program from June 17, 1990 through March 31, 1994. A Court ordered us to pay certain persons in a lawsuit called Tyler v. Anderson.

ARE YOU ELIGIBLE TO GET PAID?

At any time between June 17, 1990 and March 31, 1994:

- (1) A doctor or chiropractor prescribed range of motion exercises for an IHSS recipient or an IHSS applicant.
- (2) Someone gave range of motion exercises to the IHSS recipient or IHSS applicant at home.
- (3) IHSS did not pay anyone for the range of motion exercises.
- (4) You are the provider/worker/homemaker who did not get paid.

OR

You are the IHSS recipient/client who paid your provider but did not get paid by IHSS or any other program.

OR

You are the IHSS applicant who paid your provider but did not get paid by IHSS or any other program.

HOW CAN YOU GET PAID?

You must fill out the Tyler Claim Form that comes with this notice.

You must mail the Tyler Claim Form on or before December 31, 2003 to:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Your claim must be postmarked no later than December 31, 2003 or it will be denied as late.

At no cost to you, you can get help, a Tyler Claim Form or more information by calling our toll-free number at 1-877-508-1327. You can also get help or a Tyler Claim Form by calling your county IHSS office.

DEADLINE FOR MAILING WITH POSTMARK: DECEMBER 31, 2003

បើសិនជាលោកអ្នកមិនអាចអានសំណើនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

如果您不能夠閱讀這份表格，請打免費電話索取翻譯本。
Chinese

Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

TYLER CLAIM FORM

The claimant must file this form. The claimant is the provider not paid for range of motion exercises, or the In-Home Supportive Services (IHSS) recipient or applicant who paid the provider for the range of motion but was not paid by In Home Supportive Services or any other program.

A CLAIMANT can be any one of the following:

RECIPIENT/CLIENT: An aged, blind or disabled person who received IHSS at any time between June 17, 1990 and March 31, 1994.

PROVIDER/WORKER/HOMEMAKER: A person who provided services to an IHSS Recipient or Applicant at any time between June 17, 1990 and March 31, 1994.

APPLICANT: An aged, blind or disabled person who applied for IHSS and was denied receipt of IHSS at any time between June 17, 1990 and March 31, 1994.

INSTRUCTIONS TO THE CLAIMANT FOR COMPLETING THIS FORM:

- 1) Parts A – F: Fill out completely. Please Print. Sign your name in Part F.
- 2) Part G: Get person who received range of motion (In-Home Supportive Services (IHSS) recipient or applicant) to sign the release of medical information to the doctor or chiropractor filling out Part H.
- 3) Part H: Get the doctor or chiropractor, who prescribed range of motion or has person's medical records, to fill out and sign Part H.
- 4) Completed Parts A – H: Mail this entire form no later than December 31, 2003 to the address below.

Please do not separate.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

You can get help or more information from us by calling our toll free number at 1-877-508-1327. You can also get help by calling your county IHSS office.

Your claim must be postmarked no later than December 31, 2003 or it will be denied as late.

DEADLINE FOR MAILING WITH POSTMARK DECEMBER 31, 2003

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Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

PART A: CLAIMANT SEEKING PAYMENT

NAME (LAST, FIRST MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)
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1. Are you the Recipient, Applicant or Provider Claimant? (Please check the one that applies to you, see the definition of each on the first page)

☐ RECIPIENT ☐ APPLICANT ☐ PROVIDER

PART B: IHSS RECIPIENT OR APPLICANT WHO RECEIVED RANGE OF MOTION EXERCISES**THIS PERSON RECEIVED RANGE OF MOTION EXERCISES:**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (NUMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

COMPLETE QUESTIONS 1-3 BELOW ONLY IF THIS PERSON WAS THE IHSS APPLICANT WHO WAS DENIED IHSS SERVICES:

1. When was the applicant denied IHSS? (month/year) ____/____
2. What county denied the application? _____
3. Did you receive Supplemental Security Income/State Supplementary Payment income at any time during June 1990 – March 1994?

☐ YES ☐ NO

If yes, check each year that the applicant got Supplemental Security Income/State Supplementary Payment income

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PART C: IHSS PROVIDER OF RANGE OF MOTION EXERCISES**THIS PERSON PROVIDED THE RANGE OF MOTION EXERCISES TO THE IHSS RECIPIENT OR APPLICANT NAMED IN PART B.**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (NUMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

PART D: HOURS OF RANGE OF MOTION EXERCISES PROVIDED

List the number of hours that range of motion exercises were provided to the IHSS recipient or applicant for each month between June 17, 1990 and March 31, 1994, for which you want to be paid:

1990	
MONTH	HOURS
JUNE 17 TH - 30 TH	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1991	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1992	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1993	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	

1993	
MONTH	HOURS
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1994	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	

In what county(s) did you receive or provide the range of motion exercises? _____

PART E: PAYMENT CLAIMED

Answer only one of these questions:

1. ***If you are the Provider - Claimant:*** Were you paid for providing the hours of range of motion exercises listed above? ☐ YES ☐ NO
2. ***If you are the Recipient or Applicant - Claimant:*** Did you pay your provider for providing range of motion exercises and have not been paid by IHSS or any other program? ☐ YES ☐ NO

PART F: CLAIMANT'S DECLARATION UNDER PENALTY OF PERJURY

As the Claimant for Tyler v. Anderson I understand that the information provided on this Claim Form is subject to verification and that my signature on this form is an authorization for such investigation.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

SIGNATURE OF PERSON FILING CLAIM OR PARENT OR GUARDIAN OF CLAIMANT

DATE

**PART G: AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION BY THE
IHSS RECIPIENT OR APPLICANT**

_____ received the range of motion exercises listed in Part D.
(Name of person in Part B)

I or my authorized agent allow the doctor or chiropractor filling out Part H to release any medical information in my file relating to my need for range of motion exercises to the California Department of Social Services.

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE

DATE

PRINT RELATIONSHIP IF NOT IHSS RECIPIENT OR PROVIDER

PART H: DOCTOR OR CHIROPRACTOR CERTIFICATION

Dear Doctor or Chiropractor:

This claim is for payment for providing range of motion exercises to the IHSS recipient or applicant (patient listed above) at any time between June 17, 1990 and March 31, 1994 (claim period). A court has ordered us to make the payments to eligible claimants.

One condition for payment is that a doctor or chiropractor must have prescribed the range of motion exercises or must state, based on a review of the patient's medical records that the patient was prescribed range of motion exercises.

Please review your records. If your records show that the patient was prescribed range of motion exercises at any time during the claim period, please fill out part H and sign at the end. The claimant may not be paid without this information. Thank you for your help.

DOCTOR IDENTIFICATION

NAME (LAST, FIRST, MI)	LICENSE NUMBER	SPECIALITY
BUSINESS ADDRESS		TELEPHONE NUMBER ()
CITY	STATE	ZIP CODE

PRESCRIPTION FOR RANGE OF MOTION EXERCISES

- At any time during the claim period did you prescribe range of motion exercises for the patient?
☐ YES ☐ NO
- Based on your review of the patient's medical file, was the patient prescribed range of motion exercises during the claim period?
☐ YES ☐ NO

AMOUNT OF HOURS PRESCRIBED

How much range of motion exercise was prescribed during any of the following months?

1990		
Month	Minutes	Time per Week
JUNE 17 TH 30 TH		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1991		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1993		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		

1994		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		

Additional Comments/Considerations: _____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that prescribing range of motion exercises falls within the scope of my practice and license. In my judgment range of motion exercises was necessary to maintain the patient's health and could be performed by the patient for himself or herself but for his or her functional impairment.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

DOCTOR SIGNATURE

DATE

NOTIFICACION SOBRE TYLER

ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO

El Estado de California no pagó por servicios relacionados al “arco de movimiento” (conocido en inglés como “range of motion”) para las personas ancianas, ciegas, o discapacitadas en el programa de IHSS entre el 17 de junio de 1990 y el 31 de marzo de 1994. La corte nos ordenó que pagáramos a ciertas personas en una demanda llamada Tyler v. Anderson.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR UN PAGO?

En cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994:

- (1) Un doctor o quiropráctico recetó ejercicios para el arco de movimiento a un beneficiario o solicitante de IHSS.
- (2) Alguien proporcionó ejercicios para el arco de movimiento al beneficiario o al solicitante de IHSS.
- (3) El programa de IHSS no le pagó a nadie por los ejercicios para el arco de movimiento.
- (4) Usted es el proveedor/trabajador/persona que proporciona servicios domésticos y no le pagaron;

O,

Usted es el beneficiario/cliente que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa;

O,

Usted es el solicitante que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa.

¿COMO PUEDE RECIBIR SU PAGO?

Tiene que llenar el formulario de reclamación Tyler que viene con esta notificación.

Tiene que enviar el formulario de reclamación Tyler a más tardar para el 31 de diciembre de 2003 al:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Su reclamo tiene que tener el sello con la fecha postal a más tardar el 31 de diciembre de 2003, o se negará por no haberse recibido a tiempo.

Usted puede obtener ayuda gratuitamente, un formulario de reclamación Tyler o mayor información llamando a nuestro número gratuito 1-877-508-1327. También puede obtener ayuda o un formulario de reclamación Tyler llamando a su oficina de IHSS del condado.

FECHA LIMITE PARA EL MATASELLOS ES EL 31 DE DICIEMBRE DE 2003

FORMULARIO DE RECLAMACION TYLER

El reclamante tiene que presentar este formulario. El reclamante puede ser el proveedor que no fue pagado por ejercicios para el arco de movimiento, o puede ser el beneficiario o solicitante de Servicios de Casa y Cuidado Personal (IHSS) que le pagó al proveedor por los ejercicios, pero no fue reembolsado ni por IHSS ni por ningún otro programa.

Un RECLAMANTE puede ser cualquiera de las siguientes personas:

BENEFICIARIO/CLIENTE: Una persona de edad avanzada, ciega o discapacitada que recibió IHSS en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

PROVEEDOR: Una persona que proporcionó servicios a un beneficiario o solicitante en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

SOLICITANTE: Una persona de edad avanzada, ciega o discapacitada que solicitó IHSS y fue negada en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

INSTRUCCIONES AL RECLAMANTE PARA LLENAR ESTE FORMULARIO:

- 1) Partes A – F: Llène completamente el formulario. Favor de usar letra de molde. Firme su nombre en la parte F.
- 2) Parte G: Haga que la persona que recibió los ejercicios para el arco de movimiento (el beneficiario o solicitante de IHSS) firme la autorización para que el doctor o quiropráctico que llene la parte H comparta su información médica con el Estado.
- 3) Parte H: Haga que el doctor o quiropráctico que recetó los ejercicios para el arco de movimiento, o que tiene los archivos médicos de la persona, llene y firme la parte H.
- 4) Partes completadas A – H: Mande este formulario entero a más tardar para el 31 de diciembre de 2003 a la siguiente dirección.

Favor de no separar las hojas.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

Puede obtener ayuda o más información llamando a nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda llamando a su oficina local de IHSS.

Su reclamo se tiene que marcar con matasellos a más tardar el 31 de diciembre de 2003, o se lo negará por tardanza.

FECHA LIMITE PARA LA FECHA POSTAL ES EL 31 DE DICIEMBRE DE 2003

PARTE A: RECLAMANTE QUE SOLICITA EL PAGO

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)
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1. ¿Qué clase de reclamante es usted: Beneficiario, Solicitante o Proveedor? (Favor de marcar el que pertenece a usted; vea la definición de cada uno en la primera página)

☐ BENEFICIARIO ☐ SOLICITANTE ☐ PROVEEDOR

PARTE B: BENEFICIARIO O SOLICITANTE DE IHSS QUE RECIBIO EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA RECIBIO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO:**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE APARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

COMPLETE LAS PREGUNTAS 1-3 A CONTINUACION SOLAMENTE SI ESTA PERSONA FUE EL SOLICITANTE AL QUE SE LE NEGARON LOS SERVICIOS DE IHSS:

- ¿Cuándo se le negaron al solicitante los servicios de IHSS? (mes/año) ____/____
- ¿Cuál condado negó la solicitud? _____
- ¿Recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado durante cualquier momento durante junio de 1990 - marzo de 1994?

☐ SI ☐ NO

Si contestó "SI", marque cada año en que el solicitante recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PARTE C: PROVEEDOR DE IHSS QUE PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO AL BENEFICIARIO O SOLICITANTE DE IHSS NOMBRADO EN LA PARTE B.**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE DEPARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

PARTE D: HORAS EN QUE SE PROPORCIONARON LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

Anote el número de horas en que se proporcionaron los ejercicios para el arco de movimiento al beneficiario o solicitante de IHSS, en cada mes entre el 17 de junio de 1990 y el 31 de marzo de 1994, por las que quiere ser pagado:

1990	
MES	HORAS
JUNIO 17 - 30	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1991	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1992	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1993	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	

1993	
MES	HORAS
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1994	
MES	HORAS
ENERO	
FEBRERO	
MARZO	

¿En cuál(es) condado(s) recibió o proporcionó usted los ejercicios para el arco de movimiento? _____

PARTE E: PAGO RECLAMADO

Conteste solamente una de las siguientes preguntas:

1. **Si usted es el Reclamante - Proveedor:** ¿Se le pagó a usted para proporcionar las horas de ejercicios para el arco de movimiento indicadas arriba? ☐ SI ☐ NO
2. **Si usted es el Reclamante - Beneficiario o Solicitante:** ¿Usted le pagó al proveedor para proporcionar los ejercicios para el arco de movimiento, y no ha sido reembolsado ni por IHSS ni por ningún otro programa? ☐ SI ☐ NO

PARTE F: DECLARACION DEL RECLAMANTE BAJO PENA DE PERJURIO

Como reclamante para Tyler v. Anderson, yo entiendo que la información proporcionada en este formulario de reclamación está sujeta a la verificación y que mi firma en este formulario autoriza tal investigación.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

FIRMA DE LA PERSONA QUE PRESENTA EL RECLAMO, O PADRE O TUTOR LEGAL DEL RECLAMANTE

FECHA

PARTE G: AUTORIZACION DEL BENEFICIARIO O SOLICITANTE DE IHSS PARA COMPARTIR INFORMACION MEDICA

_____ recibió las horas de ejercicios para el arco de movimiento anotadas en la parte D.
(Nombre de la persona en la parte B)

Yo o mi agente autorizado le permite al doctor que llene la parte H que comparta con el Departamento de Servicios Sociales de California (California Department of Social Services) cualquier información médica en mi expediente que esté relacionada con mi necesidad de los ejercicios para el arco de movimiento.

FIRMA DEL PACIENTE O REPRESENTANTE AUTORIZADO

FECHA

ESCRIBA SU RELACION SI NO ES BENEFICIARIO NI PROVEEDOR DE IHSS

PARTE H: CERTIFICACION DEL DOCTOR O QUIROPRACTICO

Estimado Doctor o Quiropráctico:

Este reclamo es para el pago al beneficiario o solicitante de IHSS (el paciente nombrado arriba) para la proporción de ejercicios para el arco de movimiento en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 (el período de reclamación). La corte nos ha ordenado que hagamos los pagos a los reclamantes elegibles.

Una condición para que se reciba el pago es que un doctor o quiropráctico tiene que haber recetado los ejercicios para el arco de movimiento, o tiene que declarar, según una revisión del expediente médico del paciente, que al paciente se le recetaron los ejercicios para el arco de movimiento.

Favor de revisar sus expedientes. Si sus expedientes muestran que al paciente se le recetaron los ejercicios para el arco de movimiento en cualquier momento durante el período de reclamación, favor de llenar la parte H y firmar al final. Al reclamante no se le puede pagar sin esta información. Gracias por su ayuda.

IDENTIFICACION DEL DOCTOR/QUIROPRACTICO

NOMBRE (NOMBRE, APELLIDO, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE LICENCIA	ESPECIALIDAD
DIRECCION DE NEGOCIOS		NUMERO DE TELEFONO ()
CIUDAD	ESTADO	CODIGO POSTAL

RECETA PARA LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

- En cualquier momento durante el período de reclamación, ¿le recetó usted los ejercicios para el arco de movimiento al paciente?
☐ SI ☐ NO
- Según su revisión del expediente médico del paciente, ¿se le recetaron al paciente los ejercicios para el arco de movimiento durante el período de reclamación?
☐ SI ☐ NO

CANTIDAD DE HORAS RECETADAS

¿Cuánto ejercicio para el arco de movimiento fue recetado durante los meses siguientes?

1990		
Mes	Minutos	Total por Semana
JUNIO 17 - 30		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICEMBRE		

1991		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1993		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		

1994		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		

Comentarios/consideraciones adicionales _____

CERTIFICACION

Yo certifico que tengo licencia para practicar en el Estado de California y que el recetar los ejercicios para el arco de movimiento está dentro de la esfera de mi profesión y licencia. A mi juicio, los ejercicios para el arco de movimiento fueron necesarios para mantener la salud del paciente, y los pudiera hacer el paciente mismo(a) si no fuera por su impedimento funcional.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son correctas y verdaderas.

FIRMA DEL DOCTOR/QUIROPRACTICO

FECHA

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



January 22, 2001

ALL-COUNTY LETTER 08-01

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IHSS PROGRAM MANAGERS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
☐ Federal Law or Regulation
Change
☒ Court Order
☐ Clarification Requested by
One or More Counties
☐ Initiated by CDSS

**SUBJECT: IMPLEMENTATION OF THE TYLER V. ANDERSON JUDGMENT IN THE
IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM**

REFERENCES: ALL-COUNTY INFORMATION NOTICE I-99-99
ALL-COUNTY INFORMATION NOTICE I-121-00
ALL-COUNTY INFORMATION NOTICE I-01-01

The Sacramento County Superior Court approved the Tyler v. Anderson settlement agreement in a judgment on January 22, 1999. The purpose of this letter is to provide counties with information and materials needed for the implementation of the judgment. Attached are the following documents:

1. A copy of the Tyler v. Anderson final court judgment
2. A copy of the Stipulation and Order amending the judgment
3. A copy of the proposed emergency regulations
4. A copy of the Tyler Notice, Claim Form, Supplemental Applicant Claim Form and the Public Notice (Poster)

Judgment Background

Tyler v. Anderson was a class action lawsuit filed against the California Department of Social Services (CDSS). The suit challenged the CDSS policy of denying range of motion (ROM) exercises as a paramedical service in the IHSS Program for the period from June 17, 1990 through March 31, 1994. The final judgment requires CDSS to make retroactive payments including pre-judgment and post-judgment interest at the legal rate of seven percent to class members who received or provided ROM, but were not paid from June 17, 1990 through March 31, 1994.

CDSS created a special unit in the Adult Programs Branch to implement all the provisions of the judgment. To fulfill the requirements of the judgment emergency regulations, a notice and claim form, public notice, and computer system to process claims were developed.

IMPLEMENTATION INFORMATION

County Role

County involvement in the requirements of the judgment is minimal, since the CDSS is responsible for processing claims for payment. Though involvement is minimal, counties will need to:

- Display the Tyler Poster for the duration of the claim period.
- Provide a Tyler Claim Form to anyone asking for one.
- Provide help with filling out the Tyler Claim Form when a claimant asks for assistance.
- Provide claimants with case file information if requested in order to get the claim form completed by their doctor.
- Provide CDSS with additional information when needed in order to make a claim determination.
 - A sheet will be faxed to the county contact with the information being requested.

Class Member Mailing

The Tyler Notice and Claim Form will be mailed in English and Spanish to approximately 482,000 class members during the week of January 22, 2001. The notice and claim form will be mailed to all IHSS recipients and providers who were on the Case Management Information and Payrolling System from May 1990 through March 1994. We will fax two flyers one on January 10th and one on January 20th to remind counties about this mailing and provide instructions on how they can obtain more information. It is anticipated that the volume of calls will be high during the first few weeks after the mailing and counties may receive calls from potential claimants. If this occurs, counties can refer potential claimants to the toll free number at 1-877-508-1327 or supply them with a notice and claim form.

We will also be mailing the Tyler Notice, Claim Form and Poster in English and Spanish to county welfare departments, district offices, regional centers, independent living centers, legal aid programs, and other agencies and organizations provided by plaintiffs' counsel the week of January 8, 2001. Each county office is required to display the poster in a prominent place and have the notice and claim form available for anyone who requests one for the duration of the claim period. All other agencies and organizations are being asked to display the poster and provide claim forms to those asking for one.

Claim Period & Filing a Claim

The claim period to file a claim for retroactive benefits is from February 1, 2001 through July 31, 2001. Any claim filed after July 31, 2001, will be considered untimely and will be denied. The claim period should not be confused with the retroactive period, which is June 17, 1990 through March 31, 1994 for which benefits can be claimed. In order to file a claim the Tyler Claim Form must be completed and sent to: *CDSS – Tyler Claim, 744 P Street, M.S. 19-04, Sacramento, California 95814*. If a claimant has questions or needs assistance they may call our toll free number at 1-877-508-1327.

IMPLEMENTATION DOCUMENTS

Proposed Emergency Regulations

Attached are the proposed emergency regulations. The regulations are based upon the Tyler settlement agreement and are intended to provide a method of determining eligible claimants and provide notification to potential claimants. The regulations will also establish claimant, departmental, and county responsibilities, define retroactive eligibility periods, establish the claiming process, set forth the method for calculating benefits and interest, and establish the requirements of these benefits.

It is anticipated that these regulations will be effective in January 2001 upon approval of the Office of Administrative Law and filed with the Secretary of State. Counties will receive an approved version of these regulations through the normal distribution process when the regulations are approved. Until this occurs counties are encouraged to use the enclosed proposed emergency regulations.

Tyler Notice, Claim Form and Poster

Attached are copies of the Tyler Notice (TEMP 2185) and the Tyler Claim Form (TEMP 2185A) in both English and Spanish. These forms will also be available in the languages of Cambodian, Chinese, Russian, and Vietnamese upon request.

The Tyler Poster (TEMP 2189) is modeled after the notice and is also available in both English and Spanish. Tag lines in the languages of Cambodian, Chinese, Russian, and Vietnamese are on the poster, which provides instructions on how to get a claim form in one of these languages.

Tyler Supplemental Applicant Claim Form

The Tyler Supplemental Applicant Claim Form (TEMP 2185B) will be used to determine financial and categorical eligibility for IHSS. This form will be issued to claimants only after a claim form has been completed and the CDSS is unable to determine eligibility based upon the information provided on the claim form and the county case file does not contain sufficient information to determine retroactive IHSS eligibility.

MISCELLANEOUS INFORMATION

County Fiscal Claiming

Information on fiscal claiming for Tyler v. Anderson was provided in County Fiscal Letter (CFL) 00/01-48, dated December 22, 2000. The administrative activities related to this judgment will be reported to Time Study Code 1042, IHSS – NON HR/NON PCSP. Information regarding the Tyler v. Anderson allocation was released in CFL 00-01-14, dated, July 19, 2000. Please reference these CFL's for further fiscal information.

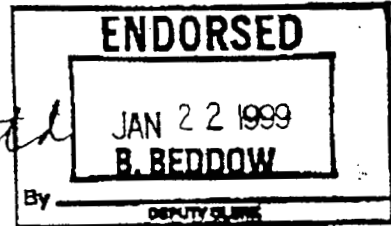
If you have any questions regarding this ACL, the implementation of this judgment or the enclosed materials, please contact Alan Stoltmack, Chief of the Adult Programs Branch or Suzie King, of the Tyler Unit at (916) 229-4000.

Sincerely,

*Original Signed By
Donna L. Mandelstam on 1/22/01*

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachments



8
9

SUPERIOR COURT OF CALIFORNIA

SACRAMENTO COUNTY

10 KATHRYN E. TYLER, GARY TYLER,) CASE NO. 376230
11 JACK D. TYLER, a minor, and)
12 MATHEW L. TYLER, a minor, both)
13 minors by their parents and)
14 guardians ad litem, KATHRYN E.) JUDGMENT
15 TYLER and JACK TYLER,)
16 individually and on behalf of)
17 other similarly situated,)
18 Plaintiffs-Petitioners,)
19 V.)
20 ELOISE ANDERSON, Director, State)
21 Department of Social Services,)
22 and STATE DEPARTMENT OF SOCIAL)
23 SERVICES,)
24 Defendants-Respondents.)

25 The parties' Joint Motion To Approve Class Action
26 Settlement And Entry Of Judgment was heard on January 22, 1999 at
27 1:30 p.m. in Department 33, Judge Lloyd G. Connelly, Judge
28 presiding. Charles Wolfinger appeared for plaintiffs, and Mateo
Munoz, Deputy Attorney General, appeared for defendants.

This court, having considered the pleadings and papers on
file herein and the argument of counsel,

1 HEREBY ORDERS, ADJUDGES AND DECREES:

2 I. DECLARATORY JUDGMENT

3 This court makes the following declaration of the
4 parties' rights and duties under Code of Civil Procedure section
5 1060:

6 A. Defendants' Violations Of State Laws

7 Defendants violated the rights of plaintiffs and the
8 certified class defined as "...all applicants for or recipients
9 of In-Home Supportive Services and their providers, who since
10 June 17, 1990, have been denied range of motion exercises under
11 the IHSS program solely because of defendants' policy prohibiting
12 them as a paramedical service under Welfare and Institutions Code
13 section 12300.1, before it was amended by Assembly Bill 1773,
14 Stats.1992, c.939" (Order. . . Granting Plaintiffs' Motion For
15 Class Certification, filed May 23, 1994) (collectively "certified
16 class") as follows. Defendants' enforcement of their official
17 policy prohibiting range of motion exercises as a paramedical
18 service under the In-Home Supportive Services Program (IHSS) from
19 about 1990 to 1993 (ROM prohibition policy) violated Welfare and
20 Institutions Code section 12300.1 (before it was amended by
21 Assembly Bill 1773, Stats.1992, c.939), because that section gave
22 defendants no discretion to prohibit range of motion exercises
23 when ordered by a licensed health care professional.

24 B. Defendants' Duty To Pay Retroactive Benefits

25 1. As a result of the violations of state laws,
26 defendants have a duty to pay plaintiffs and the class
27 retroactive benefits as follows:
28

1 a. all IHSS compensation for range of motion
2 exercises provided that was denied pursuant to their ROM
3 prohibition policy from June 17, 1990 through March 31, 1994;

4 b. prejudgment interest at the legal rate of 7% on
5 the amount of benefits from the date of the first payment was
6 originally owed but for defendants' ROM prohibition policy to the
7 date of this judgment; and

8 c. postjudgment interest at the legal rate of 7% on
9 the amount of benefits from the date of this judgment until paid.

10 2. Eligibility conditions for retroactive benefits:

11 A class member is eligible for retroactive benefits based
12 on the ROM prohibition policy based on all the following:

13 a. At any time from June 17, 1990 through March 31,
14 1994, a doctor prescribed range of motion exercises for an IHSS
15 recipient or applicant, and

16 b. At any time from June 17, 1990 through March 31,
17 1994, a provider performed range of motion exercises prescribed
18 for an IHSS recipient or applicant and was not paid therefor.

19
20 II. WRIT OF MANDATE TO PAY RETROACTIVE BENEFITS

21 Let a writ of mandate issue pursuant to Code of Civil
22 Procedure section 1085 on behalf of plaintiffs and the certified
23 class, commanding defendant Anderson, her successors in office,
24 defendant State Department of Social Services (DSS), its
25 officers, employees, agents, representatives, and all other
26 persons acting in their behalf or subject to their control or
27 supervision (collectively "defendants"), including their
28

1 statutory agents, the board of supervisions of each county of
2 California and the directors of each county welfare department to
3 (collectively "county") to comply with their mandatory duties as
4 follows:

5 A. Develop An Explanatory Notice And A Claim Form

6 1. Develop an explanatory notice about the right to
7 claim retroactive benefits (notice) and a provider/recipient
8 claim form (claim form), which are written in plain language in
9 English and Spanish.

10 2. Develop a poster size notice not less than 17" x 22"
11 in size (public notice), with the contents of the notice and in a
12 format that attracts attention when posted in a public space.

13 B. Identify Class Members

14 1. Identify IHSS recipient class members and their
15 providers and their last known addresses:

16 a. Identify all IHSS recipients and providers from
17 June 17, 1990 through March 31, 1994 in all counties except in
18 Los Angeles, Fresno, San Bernardino, Amador, Tehama and Calaveras
19 Counties.

20 b. Determine the current mailing address from the
21 IHSS payrolling system for all members currently receiving IHSS.

22 c. Determine any updated mailing address for those
23 recipients and providers not in the current IHSS payrolling
24 system, by using Medi-Cal records or if unavailable, by using the
25 address matching services of the Franchise Tax Board.

1 d. Obtain a list of all persons and their updated
2 addresses whose notices are returned in order to allow review by
3 defendants and class counsel.

4 2. Identify IHSS applicant class members and their
5 providers:

6 a. Develop a list of all county welfare offices and
7 organizations and agencies designated by plaintiffs including
8 regional centers, independent living centers, areas boards, and
9 legal aid programs for mailing poster notices and regular notices
10 and claim forms.

11 C. Notify Class Members About Retroactive Benefits

12 1. Mail notices and claim forms and the public notices
13 to all persons and others identified in paragraph II.B above.

14 2. Mail sufficient numbers of public notices, plus a
15 copy of the notice and claim form to:

16 a. Each county welfare department with instructions
17 to display the posters in prominent locations in every office
18 having contact with the public for six (6) month period beginning
19 with the effective date of the claim period as contained in the
20 regulations.

21 b. All organizations and groups on a list supplied
22 by plaintiffs' counsel with a letter request to display the
23 posters in a prominent location for six (6) month period
24 beginning with the effective date of the claim period as
25 contained in the regulations, and with camera ready copies of the
26 notice of rights and claim form.

1 3. Mail all notices in the week before the start of the
2 claiming period.

3 4. Returned notices will be retained for review by
4 defendants and class counsel for 60 days after the close of the
5 claim period.

6 D. Determine Eligibility For Retroactive Benefits

7 1. Defendants have the discretion and reserve the right
8 to process claims centrally or in affected individual counties
9 using county staff.

10 2. The claim period shall be six calendar months
11 beginning in the month after the effective date of the
12 regulations implementing this judgment under paragraph III.A.

13 3. Proof of eligibility conditions:

14 a. A doctor's statement that an IHSS recipient or
15 applicant was prescribed range of motion exercises and the hours
16 of such exercises prescribed monthly during the relevant time
17 period. The doctor signing the statement need not be the doctor
18 prescribing the range of motion exercises, but must base the
19 statement on the medical records of the recipient or applicant.

20 b. A recipient, applicant or provider's statement,
21 signed under penalty of perjury, that range of motion exercises
22 were provided during the relevant time period and the hours
23 provided monthly.

24 c. An IHSS applicant must also submit proof of
25 meeting all other categorical and financial eligibility
26 conditions for the receipt of IHSS during the relevant period and
27
28

1 a statement indicating filing an application for IHSS benefits
2 during the relevant period.

3 4. Computation of amount of retroactive benefits

4 a. The amount of hours authorized for ROM each month
5 multiplied by the county's applicable individual provider hourly
6 wage during each month for which benefits are claimed.

7 b. The amount of hours for range of motion
8 retroactive benefits may not exceed the applicable statutory
9 grant maximum. The applicable statutory grant maximum shall be
10 based on the additional monthly hours of range of motion
11 exercises allowed during each month of the retroactive period.

12 c. A share of cost will be calculated for applicants
13 utilizing the current SSI/SSP payment standards in computing the
14 amount of retroactive benefits due.

15 5. As appropriate, issue regulations and other
16 implementation plans (e.g., CMIPS instructions, automated notice
17 of action messages) concerning claim processing, which must
18 include:

19 a. Limit eligibility information for retroactive
20 benefits from class members to the claim form.

21 b. Use existing case files to establish all IHSS
22 status and income eligibility conditions.

23 c. Provide adverse information in notice of action
24 with an opportunity to submit additional information.

25 E. Issue Notice Of Action

26 Issue and mail a Notice of Action on each claim as
27 follows:

1 1. Within sixty (60) days after receiving the claim
2 form.

3 2. For every month retroactive benefits are claimed:

4 a. the computation of the amount due and prejudgment
5 and postjudgment interest; or

6 b. reasons and facts why no amount is due or less
7 due than claimed, including a statement of what additional
8 information is needed or adverse information, and that the
9 claimant must provide it within forty-five (45) days from the
10 date of the Notice of Action.

11 3. The total retroactive benefits and prejudgment and
12 postjudgment interest.

13 4. A statement about the taxability of wages,
14 withholding taxes, and deeming for SSI recipients whose providers
15 are currently spouses or parents of minor children recipients.

16 5. A statement about the right to a state hearing and
17 the procedures for obtaining one.

18 F. Issue Payment

19 1. Mail payment on or before the 10th of the month or
20 hold them for mailing on or before the 10th of the following
21 month.

22 2. Except as extended by subparagraph II.F.1, mail
23 payment within 30 days after the date of a notice of action for
24 payment is mailed to the claimant.

1 III. WRIT OF MANDATE ON COMPLIANCE AND OTHER ISSUES

2 Let a writ of mandate issue pursuant to Code of Civil
3 Procedure section 1085 on behalf of plaintiffs and the certified
4 class and commanding defendants to take the following actions:

5 A. Issue Regulations

6 1. Develop regulations, notices, claim forms and other
7 implementation procedures in consultation with class counsel.

8 2. Provide plaintiffs' counsel with the defendants'
9 final text of proposed regulations, notice, claim forms and
10 public notice no later than 45 days before filing the regulations
11 with the Office of Administrative Law.

12 3. DSS shall use its best efforts to issue emergency
13 regulations to implement this judgment.

14 B. Issue Reports

15 Send class counsel the following:

16 1. Bimonthly status report on all actions taken on the
17 judgment and include basic implementation records, including
18 contracts with all agencies. The first status report is due
19 monthly.

20 2. Identification: number of recipient and provider
21 class members identified from IHSS payrolling system; number with
22 current addresses; number updated through Medi-Cal; number
23 updated through Franchise Tax Board. The report is due one month
24 after the date of mailing the notices.

25 3. Monthly claim reports by county with the number of
26 claims received, approved, denied, pending, and amount of wages
27 and interest paid, and number of claims sent to individual class
28

1 members and date(s) of mailing; number returned undelivered for
2 those with mailing addresses from IHSS payrolling system, Medi-
3 Cal, and Franchise Tax Board. The first report is due by the
4 10th of the second month of the claiming period.

5 4. Returned notices: The parties will explore the
6 feasibility of remailing returned notices.

7 5. Defendants' obligation to issue reports shall
8 terminate at the point there are no pending claims, including
9 fair hearings.

10 C. Produce Implementation Records

11 1. On request and within a reasonable period of time,
12 allow plaintiffs and their counsel or agents to inspect any and
13 all records used by defendants in implementing this judgment.

14 2. Without request and monthly, send plaintiffs' counsel
15 all fair hearing decisions and related agency position
16 statements.

17 D. Extend Time For Claiming Attorney Fees And Costs

18 Plaintiff may file any motion for attorney fees and costs
19 for work up to and including the date of the judgment within
20 ninety days of the date of this judgment, and this judgment
21 modifies and extends any and all statutory time limits for filing
22 cost memoranda and fee motions, including under Code Civil
23 Procedure section 1033 and California Rules of Court 870(b)(3)
24 and 870.1(b).

1 E. Retain Jurisdiction


2 As provided for by current California law, the court
3 retains jurisdiction over this case to insure compliance with the
4 judgment and to make such further orders thereon.

5
6 Dated: JAN 22 1999

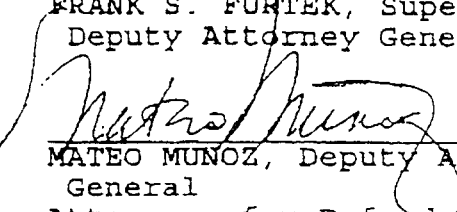
LLOYD G. CONNELLY

JUDGE OF THE SUPERIOR COURT

7
8
9 Approved as to form
10 and content

11
12 
13
14
15 CHARLES WOLFINGER
Attorney for Plaintiffs

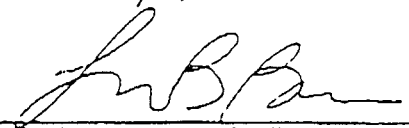
BILL LOCKYER, Attorney
General, State of California
FRANK S. FURTEK, Supervising
Deputy Attorney General

16 
17 MATEO MUNOZ, Deputy Attorney
General

Attorneys for Defendants

18 Dated: 1/7/99

Dated: 1/8/99

19 
20 LAWRENCE B. BOLTON
21 Deputy Director, Legal Division
22 California State Department of
23 Social Services

Dated: 1/8/99

24 tyljud3

1 BILL LOCKYER, Attorney General
of the State of California
2 FRANK S. FURTEK, Supervising
Deputy Attorney General
3 MATEO MUÑOZ, State Bar No. 131296
Deputy Attorney General
4 1300 I Street, Suite 1101
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5 Sacramento, CA 94244-2550
Telephone: (916) 327-7855
6 Fax: (916) 327-2319

7 Attorneys for: Defendants/Respondents
Department of Social Services and its Director
8

9 SUPERIOR COURT OF THE STATE OF CALIFORNIA
10 IN AND FOR THE COUNTY OF SACRAMENTO

11 KATHRYN E. TYLER, GARY TYLER, JACK D.
12 TYLER, et al.,

13 Plaintiffs/Petitioners,

14 v.

15 ELOISE ANDERSON, Director, State Department of
Social Services, and STATE DEPARTMENT OF
16 SOCIAL SERVICES,

17 Defendants/Respondents.

Case No. 376320

STIPULATION AND ORDER
AMENDING JUDGMENT

18 IT IS HEREBY STIPULATED by and between the parties through their respective
19 counsel:

20 In the course of developing the regulations to implement the Judgment in this case,
21 respondent Department of Social Services observed that the paragraph which sets forth the
22 eligibility conditions for retroactive benefits, paragraph (I)(B)(2), failed to expressly make
23 provisions to include a category of beneficiaries the parties intended.

24 Judgment was entered on January 22, 1999, on the parties' joint motion to approve a
25 settlement in this class action lawsuit. It was the intent of the parties in settling this action that
26 the IHSS recipients who had been denied range of motion services, but who had nevertheless
27 received and paid for these services themselves, were intended to be covered by the judgment.
28 However, during the course of developing the implementing regulations it became apparent to

1 respondent DSS the Judgment inadvertently omitted to make provisions to reimburse such
2 beneficiaries.

3 The parties therefore agree and stipulate to amend the Judgment in the manner set forth
4 below:

5 Amend paragraph (I)(B(2), subdivision (b) to read as follows:

6 "...

7 b. At any time from June 17, 1990, through March 31, 1994, a provider
8 performed range of motion exercises prescribed for an IHSS recipient or applicant and was not
9 paid therefor, or the recipient or applicant used their own funds to pay the provider for the range
10 of motion exercises provided."

11 Amend paragraph (II)(D(3), subdivision (b) to read as follows:

12 "...

13 b. A recipient, applicant or provider's statement, signed under penalty of perjury,
14 that range of motion exercises were provided during the relevant time period the hours provided
15 monthly, and

16 1. The provider was not paid for the range of motion exercises provided,

17 or

18 ///

19 ///

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

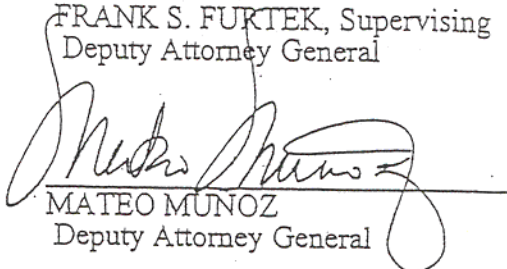
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1 2. The recipient or applicant used their own funds to pay the provider for
2 the range of motion exercises provided."

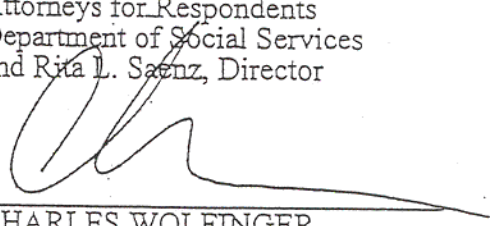
3
4 Dated: October 17, 2000

5 BILL LOCKYER, Attorney General
6 of the State of California
7 FRANK S. FURTEK, Supervising
8 Deputy Attorney General

9 
10 MATEO MUNOZ
11 Deputy Attorney General

12 Attorneys for Respondents
13 Department of Social Services
14 and Rita L. Saez, Director

15 Dated: 10/15/00

16 
17 CHARLES WOLFINGER
18 Attorney for Petitioners

19
20 GOOD CAUSE having been shown, IT IS SO ORDERED.

21 Dated: _____

22
23 _____
24 Judge Sacramento Superior Court
25
26
27
28

50-026 TYLER V. ANDERSON RETROACTIVE BENEFITS LAWSUIT

50-026

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.1 Background

On January 22, 1999, the Sacramento Superior Court approved a settlement agreement and entered the final judgment in Tyler v. Anderson.

The following provisions specify the applicable procedures in the issuance of retroactive payments to qualifying In-Home Supportive Services (IHSS) recipients, applicants and providers in compliance with the Tyler v. Anderson court order:

.11 The Lawsuit: Tyler v. Anderson is a class action lawsuit filed in 1993 against the California Department of Social Services (CDSS) and its Director. The suit challenged the CDSS policy of denying range of motion (ROM) exercises as a paramedical service in the IHSS Program. The case was certified as a class action lawsuit for all persons denied payment for ROM exercises due to the challenged policy from June 17, 1990 through March 31, 1994 under the IHSS Program. The lawsuit was settled on January 22, 1999 by a final Judgment in the Sacramento County Superior Court.

.12 The Final Judgment: The final judgment requires CDSS to make retroactive payments including prejudgment and postjudgment interest at the legal rate of 7 percent to class members for ROM provided but not paid for from June 17, 1990 through March 31, 1994 (the retroactive period) in 52 of 58 counties.

The Judgment excludes IHSS recipient/applicants and providers in six of the 58 counties: Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama. These counties continued to authorize ROM exercises during this time period. They are excluded in the lawsuit; however, they must comply with these regulations on posting the informational poster, providing notices, claim forms, assistance to claimants, and cooperating with CDSS in supplying case file information.

The Judgment requires that CDSS identify all IHSS recipients and providers from June 17, 1990 through March 31, 1994, determine the current mailing address from the IHSS Case Management, Information and Payrolling System (CMIPS) and update mailing addresses by using Medi-Cal records or if unavailable, by using the address matching services of the Franchise Tax Board.

CDSS will also develop a State Hearing process that will give the Tyler v. Anderson claim members the right to appeal any final decision on a claim.

Assembly Bill 1773 authorized ROM in the Personal Care Services Program (PCSP) which are Medi-Cal covered IHSS Program services starting April 1, 1993. PCSP was not completely implemented until all IHSS recipients had annual assessments one year later; therefore, March 31, 1994 is the end date for the retroactive period.

- .13 Forms and Notices: The Judgment requires CDSS to develop and issue forms and notices explaining the right to claim retroactive benefits: Specifically, CDSS is required to have: 1) a recipient/applicant or provider claim form written in plain language in English and Spanish, and 2) a poster size notice not less than 17" x 22" in size with the contents of the notice and in a format that attracts attention when posted in a public space.

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.2 Definitions

These definitions apply to the Tyler v. Anderson implementation.

- (a) (1) “Applicant” means a person who applied for and was denied IHSS services during the retroactive period by any county except Amador, Calaveras, Fresno, Los Angeles, San Bernardino, and Tehama counties and met the IHSS eligibility requirements in MPP Section 30-755 or 30-780.
- (b) Reserved
- (c) (1) “CDSS” means the California Department of Social Services.
- (2) “Chiropractor” means a licensed chiropractor.
- (3) “Claim Form” means a Tyler v. Anderson Claim Form (TEMP 2185A) designed and issued by CDSS which includes claiming information and the Doctor’s Certification section.
- (4) “Claim Period” means the six (6) month period in which claimants may file a claim form for retroactive payment for Range of Motion (ROM) under the IHSS Program.
- (5) “Claimant” means a person who files a claim for a retroactive payment under the Tyler v. Anderson Class Action Lawsuit.
- (6) “Class Member” means a claimant whom CDSS has determined eligible for a retroactive payment.

- (7) “CWD” means a County Welfare Department.
- (d) (1) “Days” Unless otherwise specified, all references to “days” in regard to time limits shall mean “calendar” days.
 - (2) “Doctor” means a licensed physician.
- (e) Reserved
- (f) (1) “Forms” means forms that CDSS will use only in the Tyler v. Anderson lawsuit.
- (g) Reserved
- (h) Reserved
- (i) (1) “IHSS” means the In-Home Supportive Services Program.
 - (2) “Interest” means prejudgment and postjudgment simple interest at the legal rate of 7 percent from the date of the first payment owed to the month before issuance of the retroactive payment.
- (j) Reserved
- (k) Reserved
- (l) Reserved
- (m) Reserved
- (n) (1) “NOA” means the Notice of Action sent to claimants by CDSS regarding claim determinations, as referenced in Section 50-026.
 - (2) “NOA Time Period” means the 45-day time period.
- (o) Reserved
- (p) (1) “Provider” means a person who provided IHSS ROM exercises to an IHSS recipient/applicant at any time during the retroactive period.
- (q) Reserved
- (r) (1) “Recipient” means a person who received IHSS at any time during the retroactive period except a person who received IHSS in Amador, Calaveras, Fresno, Los Angeles, San Bernardino, Tehama counties.

- (2) “Retroactive Payment” means the amount due a class member, including interest, as determined by CDSS in the claims process.
- (3) “Retroactive Period” is June 17, 1990 through March 31, 1994.
- (4) “ROM” means the Range of Motion exercises.
- (5) “ROM Prohibition Policy Period” means the payment period from June 17, 1990 through March 31, 1994.
- (s) (1) “State Hearing” means the Evidentiary Hearing provided for under Welfare and Institutions Code Section 10950 pursuant to MPP Chapter 22-000 by which a claimant may appeal a CDSS NOA.
- (t) Reserved
- (u) Reserved
- (v) Reserved
- (w) Reserved
- (x) Reserved
- (y) Reserved
- (z) Reserved

.3 Notification of Potential Claimants

.31 CDSS shall:

- .311 Develop and send the Tyler v. Anderson Notice and Claim Form to all persons who were IHSS recipients and providers during the period of June 17, 1990 through March 31, 1994, except those who were residing solely in Amador, Calaveras, Fresno, Los Angeles, San Bernardino or Tehama counties.
- .312 Update the addresses of persons identified in Section 50-026.311 from the following sources:
 - (a) The IHSS Case Management Information and Payrolling System (CMIPS) for current IHSS recipients and providers;
 - (b) Medi-Cal records;

- (c) United States Postal Fast Forward software, or
- (d) Addresses matching services of the Franchise Tax Board for all others.

.313 Provide a sufficient number of Tyler v. Anderson posters and camera-ready copies of the Tyler notice and Tyler claim form, in plain language in English and Spanish to all CWDs and agencies designated by plaintiffs' counsel, including regional centers, independent living centers, area boards, and legal aid programs.

(a) CDSS shall require CWDs to display the Tyler poster until the end of the six-month claim period in a prominent location in all offices where it may be seen by members of the public and to provide a notice and claim form to anyone asking about the case.

(b) CDSS shall request all other agencies to display the Tyler poster until the end of the six-month claim period in a prominent location and to provide a notice and claim form to anyone asking about the case.

.32 CWDs shall:

.321 Display the Tyler poster in a prominent location in all offices where it may be seen by members of the public during the entire claim period.

.322 Give a Tyler notice and Tyler claim form to anyone asking about the case.

.323 Provide assistance in the completion of the claim form to anyone asking and provide a copy of case file information relating to the provision of ROM to the recipients or their authorized representatives as required by Welfare and Institutions Code Section 10850.2.

.324 Cooperate with the CDSS in providing information deemed necessary to make a claim determination.

.4 Application for Retroactive Payments

.41 Claimant Responsibilities

.411 A claimant shall file a claim for retroactive payment on the Tyler v. Anderson claim form.

.412 A claimant shall ensure completion of all parts of the Tyler v. Anderson claim form as follows: Part A by the claimant; Part B by the IHSS recipient/applicant getting ROM; Part C by the IHSS provider administering the ROM, and Part H by the physician or chiropractor. If assistance is needed, the claimant may call 1-877-508-1327 or contact their local CWD.

.413 A claimant who is an IHSS applicant shall submit proof of meeting all other categorical and financial eligibility conditions for the receipt of IHSS during the relevant time period by completing the Tyler Supplemental Applicant Claim Form (TEMP 2185B) received from the CDSS.

.414 A claimant shall mail the completed Tyler v. Anderson claim form to CDSS, 744 P Street, Mail Station 19-04, Sacramento, CA 95814, any time within the six-month claim period but not later than July 31, 2001. For purposes of the mailing deadline, the envelope must be postmarked no later than July 31, 2001, the last day of the claim period. Claims postmarked after this date are deemed untimely and will be denied.

.42 Claim Form

.421 CDSS must stamp each claim form with the date the claim form is received.

.422 The filing date for a claim is the postmark date on the envelope containing the Tyler v. Anderson claim form.

(a) If the postmark date is not legible, the original claim date will be three days prior to the CDSS received date.

.423 If the filing date is after the claim period, the claim shall be denied.

.424 CDSS shall retain all claim forms and envelopes received in accordance with regulations governing retention of records, which is three years.

.5 Claim Processing

.51 Eligibility Conditions for Retroactive Payment

.511 A claimant must meet the conditions listed below to be eligible for a retroactive payment for any month at any time during the retroactive period.

(a) Recipient Claimant: The IHSS recipient was prescribed ROM by a doctor or chiropractor during the retroactive period, was not already at the state maximum and paid the provider for the ROM.

- (b) Provider Claimant: The IHSS provider performed ROM for the IHSS recipient or applicant and was not paid. The IHSS recipient or applicant who received the ROM was prescribed ROM by a doctor or chiropractor during the retroactive period and was not already at the state maximum. The IHSS applicant also met all of the categorical and financial eligibility conditions for the receipt of IHSS.
- (c) Applicant Claimant: The IHSS applicant met all of the categorical and financial eligibility conditions for the receipt of IHSS, applied for IHSS, was prescribed ROM by a doctor or chiropractor during the retroactive period, and paid the provider for the ROM.

.52 Claim Form Review

- .521 CDSS shall determine eligibility/ineligibility and notify the claimant of its determination within 60 days of CDSS' receipt of a complete claim form.

If additional information is needed, CDSS shall notify the claimant on a Notice of Action (NOA) and request the information to be returned within 45 days. The 45-day period shall begin to run on the first day following the date of the NOA. The claim must be postmarked on the 45th day to be considered timely. The returned information shall be date stamped "received" and CDSS will notify the claimant of its determination within 60 days of CDSS' receipt of additional information.

- .522 CDSS shall review each claim form submitted to determine if the claim form is complete. A claim form shall be considered complete when all the following requirements are met:

- (a) The following information requested in Part A must be completed as follows:

- (1) Name: Last, first, middle initial
- (2) Valid Social Security Number
- (3) Birthdate
- (4) Indicate type of claimant

- (b) The following information requested in Part B must be completed as follows:

- (1) Name: Last, first, middle initial

- (2) Valid Social Security Number
 - (3) Birthdate
 - (4) Current address
 - (5) Current telephone number
- (c) If the person was an IHSS applicant and was denied ROM exercises, the following shall also be completed in Part B.
 - (1) The date applicant was denied IHSS
 - (2) County in which the application was denied
 - (3) Indicate each year the applicant received SSI/SSP
- (d) The following information requested in Part C shall be completed if claimant was an IHSS provider.
 - (1) Name: Last, first, middle initial
 - (2) Valid Social Security Number
 - (3) Birthdate
 - (4) Current address
 - (5) Telephone number
- (e) Part D shall indicate the specific months and number of hours ROM were performed each month during the ROM prohibition policy period and in which county ROM was performed.
- (f) Part E shall indicate if the claimant was an IHSS provider, recipient or applicant and whether or not the claimant provider was paid by the IHSS recipient for ROM or the claimant recipient/applicant paid for ROM.
- (g) Part F shall show an original signature under penalty of perjury and the date the application was completed.
- (h) Part G shall indicate the name of the person who received ROM and a signed authorization for the doctor or chiropractor to release medical record information to CDSS.

(i) Part H - Doctor or Chiropractor Certification: CDSS shall review each submitted Doctor or Chiropractor Certification for completeness to determine if the doctor has provided the following information necessary to further process the claim.

(1) A doctor's or chiropractor's statement that an IHSS recipient/applicant was prescribed ROM, the number of minutes per exercise and the number of times per week prescribed monthly during the ROM prohibition policy period.

(2) The following requested Physician Information has been provided:

(A) Name: Last, first, middle initial

(B) Valid License number

(C) Specialty

(D) Business address

(E) Telephone number

(F) Signed and dated by the doctor or chiropractor

.523 When additional information is requested via a NOA and the information is returned within 45 days, each resubmitted claim form will be reviewed to determine if the claimant has provided all the necessary information to further process the claim. CDSS then has an additional 60 days to make a determination of eligibility/ineligibility.

.524 Claim Determination

CDSS may obtain additional information to verify the claim by obtaining information from the IHSS CMIPS, CWDs, Medical and Chiropractor Boards and other agencies related to the eligibility conditions for retroactive payment.

.525 Issuance of NOAs

(a) For each claim received for retroactive payments, CDSS shall mail a NOA within sixty (60) days after receiving the claim form. The NOAs shall contain, but not be limited to, the following information:

- (1) The month(s) determined eligible and/or ineligible for retroactive payments. The reason(s) for any months determined ineligible shall be clearly stated;
- (2) The amount of retroactive payments and prejudgment and postjudgment interest due for each year, if payments are claimed for more than one year during the retroactive period;
- (3) The computation of the monthly total and the grand total amount of retroactive payments and prejudgment and postjudgment interest due, and
- (4) A statement about the taxability of wages, withholding taxes, and deeming for SSI recipients whose providers are currently spouses or parents of minor children recipients.

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- (A) The required withholdings shall be deducted from the retroactive payment. Income taxes shall be withheld from all interest payments.

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- (b) Each NOA issued due to the claimant's failure to complete the claim form in its entirety shall specify those sections of the form, which were not completed as follows:
 - (1) Each part of the claim form that is incomplete.
 - (2) The original claim form shall be returned with the NOA to the claimant to mail back after filling in the missing information. CDSS shall advise the claimant that he/she has 45 days from the date of the NOA to provide the additional information. The 45-day period shall begin to run on the first day following the date of the NOA. The claim must be postmarked on the 45th day to be considered timely. Failure to respond or provide the requested information within the 45-day period shall result in a claim denial.

- (c) Each NOA issued as a result of CDSS having incomplete/contradictory/adverse information shall include a copy of the incomplete/contradictory/adverse information and if available, shall advise the claimant that he/she has 45 days from the date of the NOA to provide additional information. Failure to respond or refute the incomplete/contradictory/adverse information within the 45-day period shall result in a claim denial.
- (d) For each claim denied in full or in part, the NOA shall clearly state the reason(s) why the claim was denied and a statement that the claimant has the right to appeal the denial.
- (e) For each approved claim in which the class member is currently an IHSS recipient, the NOA shall advise the class member that the payment received as a result of his/her Tyler v. Anderson claim may adversely affect his/her IHSS services, SSI eligibility or other aid program eligibility, and that there may be a tax liability. (See 20 CFR Sections 416.1100, .1111, .1201 and .1207a.)

.6 Calculation of Retroactive Payment

.61 Issuance of Payments

- .611 CDSS shall compute the amount of retroactive payments. The amount shall be calculated using the number of hours authorized for ROM each month multiplied by the county's applicable individual provider hourly wage during each month for which benefits are claimed.
- .612 CDSS shall issue payments monthly and mail payments on or before the 10th of each month or hold the payments for mailing on or before the 10th of the following month.
- .613 Except when the time for mailing payments is extended by Section 50-026.612, CDSS shall mail payment to the claimant within 30 days after the date of the approval of the claim NOA.

.62 Prejudgment/Postjudgment Interest

- .621 Prejudgment interest for retroactive payments shall be calculated at the following rates:
 - (a) Seven percent simple interest during the time period of June 17, 1990 through March 31, 1994, on the amount of benefits from the date the first payment should have been paid, until January 22, 1999, the date of the judgment.

.622 Postjudgment interest for retroactive payments shall be calculated at the following rate:

- (a) Seven percent simple interest from the date of the judgment, January 22, 1999 until the last day of the month prior to payment.

.63 Share of Cost

.631 CDSS shall calculate the applicant's share of cost utilizing the current SSI/SSP payment standards when computing the amount of retroactive payments due.

.64 IHSS Statutory Maximum

.641 The amount of hours for ROM retroactive payments shall not exceed the applicable statutory grant maximum. Retroactive benefits shall only be awarded up to the amount which when combined with other IHSS services received during the period does not exceed the then applicable statutory maximum on the allowed IHSS hours. The IHSS statutory maximum during the ROM prohibition policy period is as follows:

<u>Effective Date</u>	<u>Nonseverely Impaired</u>	<u>Severely Impaired</u>
<u>6/17/90 - 3/31/93</u>	<u>195 hours</u>	<u>283 hours</u>
<u>4/01/93 - 3/31/94</u>	<u>195 hours</u>	<u>If PCSP, up to 283 hours</u>

- (a) When the nonseverely impaired (NSI) recipient's weekly authorized services are increased by the ROM hours and this results in a total of 20 or more hours of services defining severe impairment, the recipient shall be reclassified from NSI to severely impaired (SI), with a subsequent State maximum of 283 hours per month.

.7 General Provisions

.71 Information Requirement

.711 All information received and/or obtained in relation to the Tyler v. Anderson implementation, and all forms generated as a result of the implementation, shall be retained by CDSS in a Tyler case file for each claimant. These documents shall include, but are not limited to:

- (a) Completed Tyler claim form and any subsequent resubmittals;

- (b) Completed doctor's certification section and any subsequent resubmittals;
- (c) A copy of any NOA;
- (d) A copy of any correspondence with the CWDs in relation to a claim;
- (e) Any noted verbal communication with the CWDs in relation to a claim;
- (f) Any CMIPS records utilized, and
- (g) A copy of all other documents and records used in the determination of eligibility and computation of payments.

.72 State Hearings

- .721 The right to a state hearing on any Tyler v. Anderson claim shall be granted only to Tyler v. Anderson claimants or their authorized representatives. A Tyler v. Anderson claimant may be the recipient, applicant or provider.
- .722 A claimant has the right to appeal any final decision on a claim, including an award of less retroactive payment than claimed.

.73 Treatment of Lump Sum Payments

- .731 It will be the responsibility of the claimant in conjunction with the CWD to determine if the lump sum Tyler v. Anderson payments affect or do not affect the claimant's continued eligibility for certain other programs.
- .732 CDSS shall send the CWD a monthly list of claimants who received ROM retroactive payments. The list shall include a breakdown of principal and interest payments and the total amount received.

.74 Overpayments

CDSS shall have the right to seek and recover overpayments in accordance with IHSS regulations at MPP Section 30-768.

.75 Reports

In compliance with the Tyler v. Anderson class action Judgment, the CDSS is required to issue the following reports:

- .751 Bimonthly status report on all actions taken on the Judgment and include basic implementation records, including contracts with all agencies;
- .752 Number of recipient and provider class members identified from IHSS payrolling system; the number with current addresses; the number of updated addresses through the Department of Health Medi-Cal; and the number of addresses updated through the Franchise Tax Board, and
- .753 Monthly claim reports by county with the number of claims received, approved, denied, pending and the amount of wages and interest paid, the number of claims sent to individual class members and date(s) of mailing, number of envelopes returned undelivered for those with mailing addresses from IHSS payrolling system, Medi-Cal and Franchise Tax Board.

.8 Appendix - Tyler Forms

- .81 The following forms will be used to process Tyler V. Anderson claims:
 - .811 Tyler Public Notice (Poster) - TEMP 2189 (10/00) (English/Spanish)
 - .812 Tyler Notice - TEMP 2185 (07/00) (English/Spanish)
 - .813 Tyler Claim Form - TEMP 2185A (07/00) (English/Spanish)
 - .814 Tyler Supplemental Applicant Claim Form - TEMP 2185B (10/00) (English/Spanish)
- .82 The Tyler Claim Form and Notice will also be available in Chinese, Russian, Cambodian and Vietnamese upon request by calling the toll free number established for Tyler v. Anderson.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Sections 10950, 12300, 12300.2, 12304, 12304.5, and 14132.95, Welfare and Institutions Code and Judgment Re: Tyler v. Anderson, Sacramento Superior Court Case No. 376230, dated January 22, 1999.

Amend Section 80-310 to read:

80-310 DEFINITIONS - FORMS

80-310

The following forms apply to the regulations in Divisions 40 through 50 and 80 through 89. (Continued)

t. (1) TEMP 2189

The Tyler Public Notice (Poster) (10/00) (English/Spanish) is posted in agencies designated by plaintiffs' counsel such as CWDs, regional centers, independent living centers, area boards, and legal aid programs. This poster explains eligibility and the procedures needed for any aged, blind or disabled person in the IHSS Program to receive retroactive payments for range of motion services provided from June 17, 1990 through March 31, 1994 in the judgment of Tyler v. Anderson.

(2) TEMP 2185

The Tyler Notice (09/00) (English/Spanish) explains eligibility and the procedures needed for any aged, blind or disabled person in the IHSS program to receive retroactive payments for range of motion services provided from June 17, 1990 through March 31, 1994 in the judgment of Tyler v. Anderson.

(3) TEMP 2185A

The Tyler Claim Form (09/00) (English/Spanish) is used by a claimant to file for retroactive payments as provided in the judgment of Tyler v. Anderson.

(4) TEMP 2185B

The Tyler Supplemental Applicant Claim Form (10/00) (English/Spanish) is used by applicant claimants to file for retroactive payments to determine financial and categorical eligibility for IHSS as provided in the judgment of Tyler v. Anderson.

(45) (Continued)

u. through z. (Continued)

Authority Cited: Sections 10553, 10554, and 10604, Welfare and Institutions Code.

Reference: 45 CFR 206.10(a)(8); ~~and~~ Sections 10553, 10950, 11054, ~~and~~ 11450(b), 12300, 12300.2, 12304, 12304.5, and 14132.95, Welfare and Institutions Code, and Judgment Re: Tyler v. Anderson, Sacramento Superior Court Case No. 376230, dated January 22, 1999.

TYLER PUBLIC NOTICE

THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY

The State of California did not pay for “Range of Motion”

services for the aged, blind or disabled people in the IHSS Program from **June 17, 1990** through **March 31, 1994**. A Court ordered us to pay certain persons in a lawsuit called Tyler v. Anderson.

ARE YOU ELIGIBLE TO GET PAID?

During the period between June 17, 1990 and March 31, 1994:

- (1) A doctor or chiropractor prescribed range of motion exercises for an IHSS recipient or an IHSS applicant.
- (2) Someone gave range of motion exercises to the IHSS recipient or IHSS applicant at home.
- (3) IHSS did not pay anyone for the range of motion exercises.
- (4) You are the provider/worker/homemaker who did not get paid.
OR
You are the IHSS recipient/client who paid your provider but did not get paid by IHSS or any other program.
OR
You are the IHSS applicant who paid your provider but did not get paid by IHSS or any other program.

HOW CAN YOU GET PAID?

You must fill out the Tyler Claim Form.

You must mail the Tyler Claim Form on or before July 31, 2001 to:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

**At no cost to you, you can get help, a Tyler Claim Form or more information
by calling our toll free number at 1-877-508-1327.**

You can also get help or a Tyler Claim Form by calling your county IHSS office.

DEADLINE FOR MAILING WITH POSTMARK: JULY 31, 2001

- បើសិនជាលោកអ្នកមិនទាន់សេចក្តីប្រកាសផ្សាយនេះទេ សូមទូរស័ព្ទតាមលេខឥតបង់ប្រាក់កម្ពុជាកម្ពុជា ១ (Cambodian)
- Nếu quý vị không đọc và hiểu được nội dung của áp phích này, hãy gọi số điện thoại miễn phí để xin một bản dịch. (Vietnamese)
- 如果您看不懂這份告示的話，請打免費電話號碼索取翻譯本。(Chinese)
- Если вы не можете прочесть это объявление, пожалуйста, позвоните по бесплатному номеру и попросите перевести его. (Russian)

TYLER NOTICE

THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY

The State of California did not pay for "Range of Motion" services for the aged, blind or disabled people in the IHSS Program from June 17, 1990 through March 31, 1994. A Court ordered us to pay certain persons in a lawsuit called Tyler v. Anderson.

ARE YOU ELIGIBLE TO GET PAID?

At any time between June 17, 1990 and March 31, 1994:

- (1) A doctor or chiropractor prescribed range of motion exercises for an IHSS recipient or an IHSS applicant.
- (2) Someone gave range of motion exercises to the IHSS recipient or IHSS applicant at home.
- (3) IHSS did not pay anyone for the range of motion exercises.
- (4) You are the provider/worker/homemaker who did not get paid.

OR

You are the IHSS recipient/client who paid your provider but did not get paid by IHSS or any other program.

OR

You are the IHSS applicant who paid your provider but did not get paid by IHSS or any other program.

HOW CAN YOU GET PAID?

You must fill out the Tyler Claim Form that comes with this notice.

You must mail the Tyler Claim Form on or before July 31, 2001 to:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

At no cost to you, you can get help, a Tyler Claim Form or more information by calling our toll-free number at 1-877-508-1327. You can also get help or a Tyler Claim Form by calling your county IHSS office.

DEADLINE FOR MAILING WITH POSTMARK: JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណើនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

如果您不能夠閱讀這份表格，請打免費電話索取翻譯本。
Chinese

Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

TYLER CLAIM FORM

The claimant must file this form. The claimant is the provider not paid for range of motion exercises, or the In-Home Supportive Services (IHSS) recipient or applicant who paid the provider for the range of motion but was not paid by In Home Supportive Services or any other program.

A CLAIMANT can be any one of the following:

RECIPIENT/CLIENT: An aged, blind or disabled person who received IHSS at any time between June 17, 1990 and March 31, 1994.

PROVIDER/WORKER/HOMEMAKER: A person who provided services to an IHSS Recipient or Applicant at any time between June 17, 1990 and March 31, 1994.

APPLICANT: An aged, blind or disabled person who applied for IHSS and was denied receipt of IHSS at any time between June 17, 1990 and March 31, 1994.

INSTRUCTIONS TO THE CLAIMANT FOR COMPLETING THIS FORM:

- 1) Parts A – F: Fill out completely. Please Print. Sign your name in Part F.
- 2) Part G: Get person who received range of motion (In-Home Supportive Services (IHSS) recipient or applicant) to sign the release of medical information to the doctor or chiropractor filling out Part H.
- 3) Part H: Get the doctor or chiropractor, who prescribed range of motion or has person's medical records, to fill out and sign Part H.
- 4) Completed Parts A – H: Mail this entire form no later than July 31, 2001 to the address below.

Please do not separate.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

You can get help or more information from us by calling our toll free number at 1-877-508-1327. You can also get help by calling your county IHSS office.

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

DEADLINE FOR MAILING WITH POSTMARK JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណៅនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

如果您不能夠閱讀這份表格，請打免費電話索取翻譯本。
Chinese

Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

PART A: CLAIMANT SEEKING PAYMENT

NAME (LAST, FIRST MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)
-----------------------	------------------------	------------------------

1. Are you the Recipient, Applicant or Provider Claimant? (Please check the one that applies to you, see the definition of each on the first page)

☐ RECIPIENT ☐ APPLICANT ☐ PROVIDER

PART B: IHSS RECIPIENT OR APPLICANT WHO RECEIVED RANGE OF MOTION EXERCISES**THIS PERSON RECEIVED RANGE OF MOTION EXERCISES:**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (NUMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

COMPLETE QUESTIONS 1-3 BELOW ONLY IF THIS PERSON WAS THE IHSS APPLICANT WHO WAS DENIED IHSS SERVICES:

- When was the applicant denied IHSS? (month/year) ____/____
- What county denied the application? _____
- Did you receive Supplemental Security Income/State Supplementary Payment income at any time during June 1990 – March 1994?
☐ YES ☐ NO

If yes, check each year that the applicant got Supplemental Security Income/State Supplementary Payment income

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PART C: IHSS PROVIDER OF RANGE OF MOTION EXERCISES**THIS PERSON PROVIDED THE RANGE OF MOTION EXERCISES TO THE IHSS RECIPIENT OR APPLICANT NAMED IN PART B.**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (NUMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

PART D: HOURS OF RANGE OF MOTION EXERCISES PROVIDED

List the number of hours that range of motion exercises were provided to the IHSS recipient or applicant for each month between June 17, 1990 and March 31, 1994, for which you want to be paid:

1990	
MONTH	HOURS
JUNE 17 TH - 30 TH	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1991	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1992	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1993	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	

1993	
MONTH	HOURS
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1994	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	

In what county(s) did you receive or provide the range of motion exercises? _____

PART E: PAYMENT CLAIMED

Answer only one of these questions:

1. **If you are the Provider - Claimant:** Were you paid for providing the hours of range of motion exercises listed above? ☐ YES ☐ NO
2. **If you are the Recipient or Applicant - Claimant:** Did you pay your provider for providing range of motion exercises and have not been paid by IHSS or any other program? ☐ YES ☐ NO

PART F: CLAIMANT'S DECLARATION UNDER PENALTY OF PERJURY

As the Claimant for Tyler v. Anderson I understand that the information provided on this Claim Form is subject to verification and that my signature on this form is an authorization for such investigation.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

SIGNATURE OF PERSON FILING CLAIM OR PARENT OR GUARDIAN OF CLAIMANT

DATE

**PART G: AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION BY THE
IHSS RECIPIENT OR APPLICANT**

_____ received the range of motion exercises listed in Part D.
(Name of person in Part B)

I or my authorized agent allow the doctor or chiropractor filling out Part H to release any medical information in my file relating to my need for range of motion exercises to the California Department of Social Services.

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE	DATE
PRINT RELATIONSHIP IF NOT IHSS RECIPIENT OR PROVIDER	

PART H: DOCTOR OR CHIROPRACTOR CERTIFICATION

Dear Doctor or Chiropractor:

This claim is for payment for providing range of motion exercises to the IHSS recipient or applicant (patient listed above) at any time between June 17, 1990 and March 31, 1994 (claim period). A court has ordered us to make the payments to eligible claimants.

One condition for payment is that a doctor or chiropractor must have prescribed the range of motion exercises or must state, based on a review of the patient's medical records that the patient was prescribed range of motion exercises.

Please review your records. If your records show that the patient was prescribed range of motion exercises at any time during the claim period, please fill out part H and sign at the end. The claimant may not be paid without this information. Thank you for your help.

DOCTOR IDENTIFICATION

NAME (LAST, FIRST, MI)	LICENSE NUMBER	SPECIALITY
BUSINESS ADDRESS		TELEPHONE NUMBER ()
CITY	STATE	ZIP CODE

PRESCRIPTION FOR RANGE OF MOTION EXERCISES

- At any time during the claim period did you prescribe range of motion exercises for the patient?
☐ YES ☐ NO
- Based on your review of the patient's medical file, was the patient prescribed range of motion exercises during the claim period?
☐ YES ☐ NO

AMOUNT OF HOURS PRESCRIBED

How much range of motion exercise was prescribed during any of the following months?

1990		
Month	Minutes	Time per Week
JUNE 17 TH 30 TH		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1991		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1993		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		

1994		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		

Additional Comments/Considerations: _____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that prescribing range of motion exercises falls within the scope of my practice and license. In my judgment range of motion exercises was necessary to maintain the patient's health and could be performed by the patient for himself or herself but for his or her functional impairment.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

DOCTOR SIGNATURE

DATE

NOTIFICACION TYLER

ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO

El Estado de California no pagó por servicios relacionados al “arco de movimiento” para las personas ancianas, ciegas, o discapacitadas en el programa de IHSS entre el 17 de junio de 1990 y el 31 de marzo de 1994. La corte nos ordenó que pagáramos a ciertas personas en una demanda llamada Tyler v. Anderson.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR UN PAGO?

En cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994:

- (1) Un doctor o quiropráctico recetó ejercicios para el arco de movimiento a un beneficiario de IHSS o un solicitante de IHSS.
- (2) Alguien proporcionó ejercicios para el arco de movimiento al beneficiario de IHSS o al solicitante de IHSS en su hogar.
- (3) El programa de IHSS no le pagó a nadie por los ejercicios para el arco de movimiento.
- (4) Usted es el proveedor que no fue pagado;

o,

Usted es el beneficiario/cliente que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa;

o,

Usted es el solicitante que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa.

¿COMO PUEDE RECIBIR SU PAGO?

Tiene que llenar el formulario de reclamación Tyler que viene con esta notificación.

Tiene que enviar el formulario de reclamación Tyler a más tardar para el 31 de julio de 2001 al:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Su reclamo se tiene que marcar con matasellos a más tardar para el 31 de julio de 2001, o se lo negará por tardanza.

Sin costo a usted, puede obtener ayuda, un formulario de reclamación Tyler o mayor información llamando nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda o un formulario de reclamación Tyler al llamar a su oficina IHSS del condado.

FECHA LIMITE PARA EL MATASELLOS ES EL 31 DE JULIO DE 2001

FORMULARIO DE RECLAMACION TYLER

El reclamante tiene que presentar este formulario. El reclamante puede ser el proveedor que no fue pagado por ejercicios para el arco de movimiento, o puede ser el beneficiario o solicitante de Servicios de Casa y Cuidado Personal (IHSS) que le pagó al proveedor por los ejercicios, pero no fue reembolsado ni por IHSS ni por ningún otro programa.

Un RECLAMANTE puede ser cualquiera de las siguientes personas:

BENEFICIARIO/CLIENTE: Una persona de edad avanzada, ciega o discapacitada que recibió IHSS en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

PROVEEDOR: Una persona que proporcionó servicios a un beneficiario o solicitante en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 .

SOLICITANTE: Una persona de edad avanzada, ciega o discapacitada que solicitó IHSS y fue negada en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

INSTRUCCIONES AL RECLAMANTE PARA LLENAR ESTE FORMULARIO:

- 1) Partes A – F: Llene completamente el formulario. Favor de usar letra de molde. Firme su nombre en la parte F.
- 2) Parte G: Haga que la persona que recibió los ejercicios para el arco de movimiento (el beneficiario o solicitante de IHSS) firme la autorización para que el doctor o quiropráctico que llene la parte H comparta su información médica con el Estado.
- 3) Parte H: Haga que el doctor o quiropráctico que recetó los ejercicios para el arco de movimiento, o que tiene los archivos médicos de la persona, llene y firme la parte H.
- 4) Partes completadas A – H: Mande este formulario entero a más tardar para el 31 de julio de 2001 a la siguiente dirección.

Favor de no separar las hojas.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

Puede obtener ayuda o más información llamando a nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda llamando a su oficina local de IHSS.

Su reclamo se tiene que marcar con matasellos a más tardar el 31 de julio de 2001, o se lo negará por tardanza.

FECHA LIMITE PARA LA FECHA POSTAL ES EL 31 DE JULIO DE 2001

PARTE A: RECLAMANTE QUE SOLICITA EL PAGO

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)
--	-------------------------	----------------------------------

1. ¿Qué clase de reclamante es usted: Beneficiario, Solicitante o Proveedor? (Favor de marcar el que pertenece a usted; vea la definición de cada uno en la primera página)

☐ BENEFICIARIO ☐ SOLICITANTE ☐ PROVEEDOR

PARTE B: BENEFICIARIO O SOLICITANTE DE IHSS QUE RECIBIO EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA RECIBIO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO:**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE APARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

COMPLETE LAS PREGUNTAS 1-3 A CONTINUACION SOLAMENTE SI ESTA PERSONA FUE EL SOLICITANTE AL QUE SE LE NEGARON LOS SERVICIOS DE IHSS:

1. ¿Cuándo se le negaron al solicitante los servicios de IHSS? (mes/año) ____/____
2. ¿Cuál condado negó la solicitud? _____
3. ¿Recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado durante cualquier momento durante junio de 1990 - marzo de 1994?

☐ SI ☐ NO

Si contestó "SI", marque cada año en que el solicitante recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PARTE C: PROVEEDOR DE IHSS QUE PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO AL BENEFICIARIO O SOLICITANTE DE IHSS NOMBRADO EN LA PARTE B.**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE DEPARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

PARTE D: HORAS EN QUE SE PROPORCIONARON LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

Anote el número de horas en que se proporcionaron los ejercicios para el arco de movimiento al beneficiario o solicitante de IHSS, en cada mes entre el 17 de junio de 1990 y el 31 de marzo de 1994, por las que quiere ser pagado:

1990	
MES	HORAS
JUNIO 17 - 30	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1991	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1992	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1993	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	

1993	
MES	HORAS
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1994	
MES	HORAS
ENERO	
FEBRERO	
MARZO	

¿En cuál(es) condado(s) recibió o proporcionó usted los ejercicios para el arco de movimiento? _____

PARTE E: PAGO RECLAMADO

Conteste solamente una de las siguientes preguntas:

1. **Si usted es el Reclamante - Proveedor:** ¿Se le pagó a usted para proporcionar las horas de ejercicios para el arco de movimiento indicadas arriba? ☐ SI ☐ NO
2. **Si usted es el Reclamante - Beneficiario o Solicitante:** ¿Usted le pagó al proveedor para proporcionar los ejercicios para el arco de movimiento, y no ha sido reembolsado ni por IHSS ni por ningún otro programa? ☐ SI ☐ NO

PARTE F: DECLARACION DEL RECLAMANTE BAJO PENA DE PERJURIO

Como reclamante para Tyler v. Anderson, yo entiendo que la información proporcionada en este formulario de reclamación está sujeta a la verificación y que mi firma en este formulario autoriza tal investigación.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

FIRMA DE LA PERSONA QUE PRESENTA EL RECLAMO, O PADRE O TUTOR LEGAL DEL RECLAMANTE

FECHA

PARTE G: AUTORIZACION DEL BENEFICIARIO O SOLICITANTE DE IHSS PARA COMPARTIR INFORMACION MEDICA

_____ recibió las horas de ejercicios para el arco de movimiento anotadas en la parte D.
(Nombre de la persona en la parte B)

Yo o mi agente autorizado le permite al doctor que llene la parte H que comparta con el Departamento de Servicios Sociales de California (California Department of Social Services) cualquier información médica en mi expediente que esté relacionada con mi necesidad de los ejercicios para el arco de movimiento.

FIRMA DEL PACIENTE O REPRESENTANTE AUTORIZADO

FECHA

ESCRIBA SU RELACION SI NO ES BENEFICIARIO NI PROVEEDOR DE IHSS

PARTE H: CERTIFICACION DEL DOCTOR O QUIROPRACTICO

Estimado Doctor o Quiropráctico:

Este reclamo es para el pago al beneficiario o solicitante de IHSS (el paciente nombrado arriba) para la proporción de ejercicios para el arco de movimiento en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 (el período de reclamación). La corte nos ha ordenado que hagamos los pagos a los reclamantes elegibles.

Una condición para que se reciba el pago es que un doctor o quiropráctico tiene que haber recetado los ejercicios para el arco de movimiento, o tiene que declarar, según una revisión del expediente médico del paciente, que al paciente se le recetaron los ejercicios para el arco de movimiento.

Favor de revisar sus expedientes. Si sus expedientes muestran que al paciente se le recetaron los ejercicios para el arco de movimiento en cualquier momento durante el período de reclamación, favor de llenar la parte H y firmar al final. Al reclamante no se le puede pagar sin esta información. Gracias por su ayuda.

IDENTIFICACION DEL DOCTOR/QUIROPRACTICO

NOMBRE (NOMBRE, APELLIDO, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE LICENCIA	ESPECIALIDAD
DIRECCION DE NEGOCIOS		NUMERO DE TELEFONO ()
CIUDAD	ESTADO	CODIGO POSTAL

RECETA PARA LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

1. En cualquier momento durante el período de reclamación, ¿le recetó usted los ejercicios para el arco de movimiento al paciente?
☐ SI ☐ NO
2. Según su revisión del expediente médico del paciente, ¿se le recetaron al paciente los ejercicios para el arco de movimiento durante el período de reclamación?
☐ SI ☐ NO

CANTIDAD DE HORAS RECETADAS

¿Cuánto ejercicio para el arco de movimiento fue recetado durante los meses siguientes?

1990		
Mes	Minutos	Total por Semana
JUNIO 17 - 30		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1991		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1993		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		

1994		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		

Comentarios/consideraciones adicionales _____

CERTIFICACION

Yo certifico que tengo licencia para practicar en el Estado de California y que el recetar los ejercicios para el arco de movimiento está dentro de la esfera de mi profesión y licencia. A mi juicio, los ejercicios para el arco de movimiento fueron necesarios para mantener la salud del paciente, y los pudiera hacer el paciente mismo(a) si no fuera por su impedimento funcional.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son correctas y verdaderas.

FIRMA DEL DOCTOR/QUIROPRACTICO

FECHA

FINAL DRAFT Revised 12/28/00

TYLER V. ANDERSON
SUPPLEMENTAL APPLICANT CLAIM FORM

Claim Number: _____

We have no record of the person who applied for, and was denied IHSS during the period from 6/17/90 to 3/31/94. Please complete the following on the IHSS applicant so we can determine if the person qualifies as a Tyler v. Anderson claimant. MPP 50-026.413

Instructions: Please print. Fill in all information requested. If you need help, call the toll-free number, 1-877-508-1327 or Fax to 1-877-508-1328.

You must complete this supplemental claim form and return it to:

Tyler Unit
California Department of Social Services
744 P Street MS 19-04
Sacramento, CA 95814

Deadline: Your returned form must be postmarked within 45 days of the date on the Notice of Action. The response on your envelope will establish the return date. Proof of returning the claim form on day 45 is by postmark only.

Name of IHSS Applicant who was denied IHSS during the months claimed:

Current Address (Number, Street)

Apartment/Space Number:

City

County

State

Zip Code

1. In what county did applicant apply for IHSS?

2. When did applicant apply (month and year) for IHSS?

3. Where did the applicant live when applying for IHSS?

Check one box:

Own Home ☐

Home of a Relative ☐

Board and Care Facility ☐

4. Check each year the IHSS applicant received SSI/SSP.

1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994 ☐

5. Or, for any year not checked in question #4, complete the following:

List the average gross **monthly income** from all sources. (Include income of live-in spouse or child/children, if applicable).

Applicant: (may include eligible child)

Spouse: Check box if the spouse was blind, disabled, or 65 years or older ☐

Child/Children: The number of minor children not blind or disabled and their combined income.

	Applicant	Spouse	Number of Child/Children ____
1990	\$	\$	\$
1991	\$	\$	\$
1992	\$	\$	\$
1993	\$	\$	\$
1994	\$	\$	\$

6. Did the IHSS applicant have average monthly liquid resources (cash, checking or savings account, trust funds, checks or cash in safety deposit box, stocks or bonds, notes, mortgages, deeds) that were in excess of \$2000 (if a single person) or \$3000 (if married) at the beginning of any month during the period of 6/17/90 to 3/31/94? (Exclude your home where you lived during this time)

Yes ☐ No ☐

If yes, show which months in each year that resources exceeded these limits. For each year checked below, indicate the Months/Year:

1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994 ☐

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Do you have a copy of the IHSS Applicant's application and denial?

Yes ☐ No ☐ If yes, please send us a copy with this supplemental form.

Claimant's Statement:

I understand the information I put on this form may be verified and that my signature on this form authorizes such an investigation.

Name of Claimant:

Signature of Claimant:

Date:

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



December 22, 1999

ALL COUNTY INFORMATION NOTICE NO. I-99-99

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IHSS OFFICES
ALL IHSS PROGRAM MANAGERS
ALL COUNTY COUNSELS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☒ Court Order or Settlement Agreement
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

SUBJECT: TYLER V. ANDERSON SETTLEMENT AGREEMENT

The purpose of this All-County Information Notice (ACIN) is to provide counties with initial information regarding the settlement agreement in the Tyler v. Anderson lawsuit. Enclosed is a copy of the judgment containing the settlement agreement for your information.

BACKGROUND

Tyler v. Anderson is a class action lawsuit filed in 1993. The case involves the Department's policy of denying range of motion (ROM) exercises to In-Home Supportive Services (IHSS) recipients as paramedical services from June 17, 1990 through March 31, 1993. Since April 1, 1993, IHSS recipients have received ROM exercises as a personal care service. However, the settlement agreement extended the claimable period for another year, until March 31, 1994, because recipient re-evaluations may not have taken place for up to 12 months after the reinstatement of ROM services. The settlement agreement was approved by the Sacramento County Superior Court, in a judgment on January 22, 1999.

This settlement applies to recipients/applicants/providers of IHSS who were denied payment for ROM exercises prescribed and rendered during the specified time period (except in Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama counties who continued to provide ROM services). Under the terms of the settlement agreement, class members must be notified and are then given a six-month time frame to file a claim. Claimants with a valid claim will receive retroactive payments and interest. We believe the number of valid Tyler v. Anderson claimants will be relatively small in comparison to the total IHSS population.

COUNTY ROLE

The Department has established a new Unit to handle all of the provisions of the Tyler v. Anderson settlement agreement. The counties' role in this process will be minimal, as the Department has assumed the primary responsibility for implementing the settlement agreement and will centrally process claims. However, counties may be asked to provide case file information for some of the claims.

Although Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama counties continued to provide ROM services during the noted time period, it is possible that these counties may have residents that submit claim forms. Therefore, it will be necessary for these counties to have some familiarity with the Tyler claims process.

CLAIMS PROCESS

It is anticipated that the claims process will begin in the Spring of 2000. Counties will be notified of specific implementation procedures through an All-County Letter when the emergency regulations and forms are finalized, and the claims processing details are determined. Final emergency regulations and instructions will also be issued prior to the initiation of the claims period, and counties will be asked for input prior to their release.

COUNTY ASSISTANCE

The Tyler Unit will be working with the County Welfare Directors Association, Adult Services Committee to form a workgroup comprised of state and county staff representatives, to discuss the implementation procedures and processes. If you are interested in participating, please contact your Regional Chairperson.

In addition, we would like counties to provide us with a contact person to serve as a liaison to facilitate timely implementation and to ensure consistency in claims processing. Enclosed is a contact sheet for counties to fill out. This contact sheet should be completed and faxed to (916) 229-0337 to the attention of Lori Starnes by January 5, 2000.

If you have any questions related to this ACIN or would like to discuss the implementation of the settlement agreement, please contact Lori Starnes or Randy Brown, Manager of the Tyler Unit at (916) 229-4000.

Sincerely,

Original Signed By
Donna L. Mandelstam on December 22, 1999
DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Enclosures

TYLER LAWSUIT COUNTY CONTACT SHEET

Please Return Form by: **January 5, 2000**

To: Lori Starnes

Fax Number: (916) 229-0337

County: _____

Address: _____

COUNTY CONTACT:

Name: _____

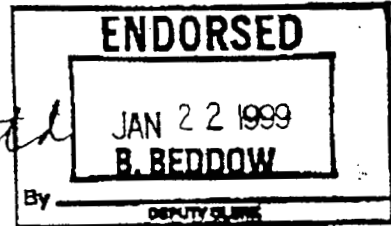
Classification: _____

Phone Number: _____

FAX Number: _____

E-mail Address: _____

Comments: _____



8
9

SUPERIOR COURT OF CALIFORNIA

SACRAMENTO COUNTY

10 KATHRYN E. TYLER, GARY TYLER,) CASE NO. 376230
11 JACK D. TYLER, a minor, and)
12 MATHEW L. TYLER, a minor, both)
13 minors by their parents and)
14 guardians ad litem, KATHRYN E.) JUDGMENT
15 TYLER and JACK TYLER,)
16 individually and on behalf of)
17 other similarly situated,)
18 Plaintiffs-Petitioners,)
19 v.)
20 ELOISE ANDERSON, Director, State)
21 Department of Social Services,)
22 and STATE DEPARTMENT OF SOCIAL)
23 SERVICES,)
24 Defendants-Respondents.)

25 The parties' Joint Motion To Approve Class Action
26 Settlement And Entry Of Judgment was heard on January 22, 1999 at
27 1:30 p.m. in Department 33, Judge Lloyd G. Connelly, Judge
28 presiding. Charles Wolfinger appeared for plaintiffs, and Mateo
Munoz, Deputy Attorney General, appeared for defendants.

This court, having considered the pleadings and papers on
file herein and the argument of counsel,

1 HEREBY ORDERS, ADJUDGES AND DECREES:

2 I. DECLARATORY JUDGMENT

3 This court makes the following declaration of the
4 parties' rights and duties under Code of Civil Procedure section
5 1060:

6 A. Defendants' Violations Of State Laws

7 Defendants violated the rights of plaintiffs and the
8 certified class defined as "...all applicants for or recipients
9 of In-Home Supportive Services and their providers, who since
10 June 17, 1990, have been denied range of motion exercises under
11 the IHSS program solely because of defendants' policy prohibiting
12 them as a paramedical service under Welfare and Institutions Code
13 section 12300.1, before it was amended by Assembly Bill 1773,
14 Stats.1992, c.939" (Order. . . Granting Plaintiffs' Motion For
15 Class Certification, filed May 23, 1994) (collectively "certified
16 class") as follows. Defendants' enforcement of their official
17 policy prohibiting range of motion exercises as a paramedical
18 service under the In-Home Supportive Services Program (IHSS) from
19 about 1990 to 1993 (ROM prohibition policy) violated Welfare and
20 Institutions Code section 12300.1 (before it was amended by
21 Assembly Bill 1773, Stats.1992, c.939), because that section gave
22 defendants no discretion to prohibit range of motion exercises
23 when ordered by a licensed health care professional.

24 B. Defendants' Duty To Pay Retroactive Benefits

25 1. As a result of the violations of state laws,
26 defendants have a duty to pay plaintiffs and the class
27 retroactive benefits as follows:
28

1 a. all IHSS compensation for range of motion
2 exercises provided that was denied pursuant to their ROM
3 prohibition policy from June 17, 1990 through March 31, 1994;

4 b. prejudgment interest at the legal rate of 7% on
5 the amount of benefits from the date of the first payment was
6 originally owed but for defendants' ROM prohibition policy to the
7 date of this judgment; and

8 c. postjudgment interest at the legal rate of 7% on
9 the amount of benefits from the date of this judgment until paid.

10 2. Eligibility conditions for retroactive benefits:

11 A class member is eligible for retroactive benefits based
12 on the ROM prohibition policy based on all the following:

13 a. At any time from June 17, 1990 through March 31,
14 1994, a doctor prescribed range of motion exercises for an IHSS
15 recipient or applicant, and

16 b. At any time from June 17, 1990 through March 31,
17 1994, a provider performed range of motion exercises prescribed
18 for an IHSS recipient or applicant and was not paid therefor.

19
20 II. WRIT OF MANDATE TO PAY RETROACTIVE BENEFITS

21 Let a writ of mandate issue pursuant to Code of Civil
22 Procedure section 1085 on behalf of plaintiffs and the certified
23 class, commanding defendant Anderson, her successors in office,
24 defendant State Department of Social Services (DSS), its
25 officers, employees, agents, representatives, and all other
26 persons acting in their behalf or subject to their control or
27 supervision (collectively "defendants"), including their
28

1 statutory agents, the board of supervisions of each county of
2 California and the directors of each county welfare department to
3 (collectively "county") to comply with their mandatory duties as
4 follows:

5 A. Develop An Explanatory Notice And A Claim Form

6 1. Develop an explanatory notice about the right to
7 claim retroactive benefits (notice) and a provider/recipient
8 claim form (claim form), which are written in plain language in
9 English and Spanish.

10 2. Develop a poster size notice not less than 17" x 22"
11 in size (public notice), with the contents of the notice and in a
12 format that attracts attention when posted in a public space.

13 B. Identify Class Members

14 1. Identify IHSS recipient class members and their
15 providers and their last known addresses:

16 a. Identify all IHSS recipients and providers from
17 June 17, 1990 through March 31, 1994 in all counties except in
18 Los Angeles, Fresno, San Bernardino, Amador, Tehama and Calaveras
19 Counties.

20 b. Determine the current mailing address from the
21 IHSS payrolling system for all members currently receiving IHSS.

22 c. Determine any updated mailing address for those
23 recipients and providers not in the current IHSS payrolling
24 system, by using Medi-Cal records or if unavailable, by using the
25 address matching services of the Franchise Tax Board.

1 d. Obtain a list of all persons and their updated
2 addresses whose notices are returned in order to allow review by
3 defendants and class counsel.

4 2. Identify IHSS applicant class members and their
5 providers:

6 a. Develop a list of all county welfare offices and
7 organizations and agencies designated by plaintiffs including
8 regional centers, independent living centers, areas boards, and
9 legal aid programs for mailing poster notices and regular notices
10 and claim forms.

11 C. Notify Class Members About Retroactive Benefits

12 1. Mail notices and claim forms and the public notices
13 to all persons and others identified in paragraph II.B above.

14 2. Mail sufficient numbers of public notices, plus a
15 copy of the notice and claim form to:

16 a. Each county welfare department with instructions
17 to display the posters in prominent locations in every office
18 having contact with the public for six (6) month period beginning
19 with the effective date of the claim period as contained in the
20 regulations.

21 b. All organizations and groups on a list supplied
22 by plaintiffs' counsel with a letter request to display the
23 posters in a prominent location for six (6) month period
24 beginning with the effective date of the claim period as
25 contained in the regulations, and with camera ready copies of the
26 notice of rights and claim form.

1 3. Mail all notices in the week before the start of the
2 claiming period.

3 4. Returned notices will be retained for review by
4 defendants and class counsel for 60 days after the close of the
5 claim period.

6 D. Determine Eligibility For Retroactive Benefits

7 1. Defendants have the discretion and reserve the right
8 to process claims centrally or in affected individual counties
9 using county staff.

10 2. The claim period shall be six calendar months
11 beginning in the month after the effective date of the
12 regulations implementing this judgment under paragraph III.A.

13 3. Proof of eligibility conditions:

14 a. A doctor's statement that an IHSS recipient or
15 applicant was prescribed range of motion exercises and the hours
16 of such exercises prescribed monthly during the relevant time
17 period. The doctor signing the statement need not be the doctor
18 prescribing the range of motion exercises, but must base the
19 statement on the medical records of the recipient or applicant.

20 b. A recipient, applicant or provider's statement,
21 signed under penalty of perjury, that range of motion exercises
22 were provided during the relevant time period and the hours
23 provided monthly.

24 c. An IHSS applicant must also submit proof of
25 meeting all other categorical and financial eligibility
26 conditions for the receipt of IHSS during the relevant period and
27
28

1 a statement indicating filing an application for IHSS benefits
2 during the relevant period.

3 4. Computation of amount of retroactive benefits

4 a. The amount of hours authorized for ROM each month
5 multiplied by the county's applicable individual provider hourly
6 wage during each month for which benefits are claimed.

7 b. The amount of hours for range of motion
8 retroactive benefits may not exceed the applicable statutory
9 grant maximum. The applicable statutory grant maximum shall be
10 based on the additional monthly hours of range of motion
11 exercises allowed during each month of the retroactive period.

12 c. A share of cost will be calculated for applicants
13 utilizing the current SSI/SSP payment standards in computing the
14 amount of retroactive benefits due.

15 5. As appropriate, issue regulations and other
16 implementation plans (e.g., CMIPS instructions, automated notice
17 of action messages) concerning claim processing, which must
18 include:

19 a. Limit eligibility information for retroactive
20 benefits from class members to the claim form.

21 b. Use existing case files to establish all IHSS
22 status and income eligibility conditions.

23 c. Provide adverse information in notice of action
24 with an opportunity to submit additional information.

25 E. Issue Notice Of Action

26 Issue and mail a Notice of Action on each claim as
27 follows:

1 1. Within sixty (60) days after receiving the claim
2 form.

3 2. For every month retroactive benefits are claimed:

4 a. the computation of the amount due and prejudgment
5 and postjudgment interest; or

6 b. reasons and facts why no amount is due or less
7 due than claimed, including a statement of what additional
8 information is needed or adverse information, and that the
9 claimant must provide it within forty-five (45) days from the
10 date of the Notice of Action.

11 3. The total retroactive benefits and prejudgment and
12 postjudgment interest.

13 4. A statement about the taxability of wages,
14 withholding taxes, and deeming for SSI recipients whose providers
15 are currently spouses or parents of minor children recipients.

16 5. A statement about the right to a state hearing and
17 the procedures for obtaining one.

18 F. Issue Payment

19 1. Mail payment on or before the 10th of the month or
20 hold them for mailing on or before the 10th of the following
21 month.

22 2. Except as extended by subparagraph II.F.1, mail
23 payment within 30 days after the date of a notice of action for
24 payment is mailed to the claimant.

1 III. WRIT OF MANDATE ON COMPLIANCE AND OTHER ISSUES

2 Let a writ of mandate issue pursuant to Code of Civil
3 Procedure section 1085 on behalf of plaintiffs and the certified
4 class and commanding defendants to take the following actions:

5 A. Issue Regulations

6 1. Develop regulations, notices, claim forms and other
7 implementation procedures in consultation with class counsel.

8 2. Provide plaintiffs' counsel with the defendants'
9 final text of proposed regulations, notice, claim forms and
10 public notice no later than 45 days before filing the regulations
11 with the Office of Administrative Law.

12 3. DSS shall use its best efforts to issue emergency
13 regulations to implement this judgment.

14 B. Issue Reports

15 Send class counsel the following:

16 1. Bimonthly status report on all actions taken on the
17 judgment and include basic implementation records, including
18 contracts with all agencies. The first status report is due
19 monthly.

20 2. Identification: number of recipient and provider
21 class members identified from IHSS payrolling system; number with
22 current addresses; number updated through Medi-Cal; number
23 updated through Franchise Tax Board. The report is due one month
24 after the date of mailing the notices.

25 3. Monthly claim reports by county with the number of
26 claims received, approved, denied, pending, and amount of wages
27 and interest paid, and number of claims sent to individual class
28

1 members and date(s) of mailing; number returned undelivered for
2 those with mailing addresses from IHSS payrolling system, Medi-
3 Cal, and Franchise Tax Board. The first report is due by the
4 10th of the second month of the claiming period.

5 4. Returned notices: The parties will explore the
6 feasibility of remailing returned notices.

7 5. Defendants' obligation to issue reports shall
8 terminate at the point there are no pending claims, including
9 fair hearings.

10 C. Produce Implementation Records

11 1. On request and within a reasonable period of time,
12 allow plaintiffs and their counsel or agents to inspect any and
13 all records used by defendants in implementing this judgment.

14 2. Without request and monthly, send plaintiffs' counsel
15 all fair hearing decisions and related agency position
16 statements.

17 D. Extend Time For Claiming Attorney Fees And Costs

18 Plaintiff may file any motion for attorney fees and costs
19 for work up to and including the date of the judgment within
20 ninety days of the date of this judgment, and this judgment
21 modifies and extends any and all statutory time limits for filing
22 cost memoranda and fee motions, including under Code Civil
23 Procedure section 1033 and California Rules of Court 870(b)(3)
24 and 870.1(b).

1 E. Retain Jurisdiction


2 As provided for by current California law, the court
3 retains jurisdiction over this case to insure compliance with the
4 judgment and to make such further orders thereon.

5
6 Dated: JAN 22 1999

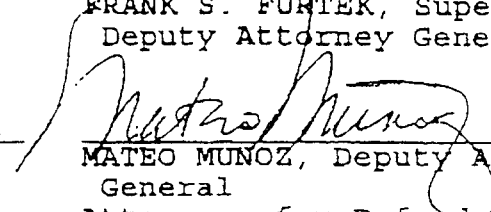
LLOYD G. CONNELLY

JUDGE OF THE SUPERIOR COURT

7
8
9 Approved as to form
10 and content

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14
15 CHARLES WOLFINGER
Attorney for Plaintiffs

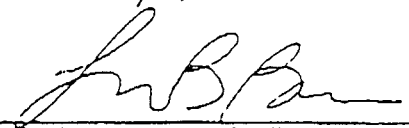
BILL LOCKYER, Attorney
General, State of California
FRANK S. FURTEK, Supervising
Deputy Attorney General

16 
17 MATEO MUNOZ, Deputy Attorney
General

Attorneys for Defendants

18 Dated: 1/7/99

Dated: 1/8/99

19 
20 LAWRENCE B. BOLTON
21 Deputy Director, Legal Division
22 California State Department of
23 Social Services

Dated: 1/8/99

24 tyljud3

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



December 8, 2000

ALL-COUNTY INFORMATION NOTICE NO. I-121-00

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IHSS OFFICES
ALL IHSS PROGRAM MANAGERS

Reason For This Transmittal

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☒ Court Order or Settlement Agreement
- ☐ Clarification Requested by one or More Counties
- ☐ Initiated by CDSS

SUBJECT: TYLER V. ANDERSON TRAINING

The purpose of this notice is to provide counties with information regarding training in the implementation of the Tyler v. Anderson judgment. Tyler v. Anderson was a class action lawsuit filed against the California Department of Social Services (CDSS) for denying range of motion exercises to In-Home Supportive Services recipients from June 17, 1990 through March 31, 1994. This lawsuit was settled on January 22, 1999. Under the terms of the judgment, class members, who are recipients, providers, or applicants, must be notified that they may be eligible for retroactive benefits and given a six-month time frame to file a claim for payment.

The CDSS Adult Programs Branch, Tyler Unit, will be responsible for the implementation of this judgment. The Tyler unit and the County Welfare Directors Association, Adult Services Committee, have formed a workgroup comprised of county regional representatives and State staff to discuss the implementation documents, claim processing, and to keep counties informed of the Department's progress.

Although the Department will be processing the claims, counties may have some involvement in the implementation of this judgment. Approximately 480,000 claim forms and notices will be mailed to class members the week of January 22, 2001. A State 1-800 number has been established to handle the Tyler inquiries. Although every effort has been taken to minimize county involvement, counties can anticipate receiving calls after this mailing occurs.

The training will assist counties in handling the inquiries and will provide counties with information regarding implementation efforts, State and county responsibility, the claim process, the claim forms, the claim period, and the requirements for a claim to be valid. All training sessions will begin at 9:30 a.m. and it is anticipated the sessions will last three to four hours. The dates and locations where the training will be held for each county region are as follows:

<u>Region</u>	<u>Date</u>	<u>Location of Training</u>	
Southern	January 4, 2001	Ventura	Public Social Services Agency 505 Poli Street, 5 th Floor Ventura, CA 93001
	January 17, 2001	San Bernardino	Aging and Adult Services 686 E. Mill Street San Bernardino, CA 92415
Central	January 9, 2001	Martinez	Social Services Department 2530 Arnold Drive Martinez, CA 94553
Northern	January 10, 2001	Redding	Department of Adult Services 1615-A Continental Redding, CA 96001
	January 11, 2001	Orland	HRA Social Services Division 604 East Walker, Suite A Orland, CA 95963
Valley Mountain	January 16, 2001	Merced	Regional Meeting TBD

Please contact Suzie King of the Tyler Unit at (916) 229-0345 with the number of attendees for each training session by December 29, 2000. Thank you for your assistance.

Sincerely,

*Original Signed By
Donna L. Mandelstam on 12/8/00*

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



January 3, 2001

ALL-COUNTY INFORMATION NOTICE NO. I-01-01

TO: ALL COUNTY WELFARE OFFICES
ALL COUNTY REGIONAL CENTER'S
AND FIELD OFFICES
INDEPENDENT LIVING CENTERS
ALL AREA BOARDS
LEGAL AID PROGRAMS
REGIONAL CENTERS
LABOR UNIONS
PUBLIC AUTHORITIES
CONTRACT PROVIDERS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☒ Court Order
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

SUBJECT: TYLER V. ANDERSON POSTER, NOTICE AND CLAIM FORMS

The purpose of this All County Information Notice (ACIN) is to inform counties about their responsibilities in the implementation of the judgment in the Tyler v. Anderson class action lawsuit, and to request that other organizations assist us with implementing the judgment. This lawsuit is a result of the California Department of Social Services (CDSS) denying range of motion (ROM) exercises as a paramedical service to In-Home Supportive Services (IHSS) recipients. The members of the class include recipients, applicants, and providers of IHSS who were denied payment for ROM exercises from June 17, 1990 through March 31, 1994 (except in Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama counties because they continued to provide ROM services). Under the terms of the judgment, class members must be notified and given a six-month time frame to file a claim. The time period to file a claim is February 1, 2001 through July 31, 2001.

In order to comply with the judgment, all county welfare offices are required to do the following:

1. Display the poster in a prominent location in every office having contact with the public for the six-month period beginning February 1, 2001 through July 31, 2001.
2. Give a Tyler notice and Tyler claim form to anyone asking about the case.

All other organizations listed above are requested to display the posters in prominent locations for the six-month period beginning February 1, 2001 through July 31, 2001 and hand out claim forms when requested. We have attached a copy of the Tyler v. Anderson judgment for your information.

Also attached are copies of the Poster(s), Notice(s) and Claim Forms to be posted and distributed for the Tyler v. Anderson lawsuit. If additional copies are needed, camera ready copies of the Notice and Claim Forms in both English and Spanish are being sent with this letter. Another source for accessing these forms is through the CDSS website: www.dss.cahwnet.gov/getinfo/default.htm.

If prospective claimants need more information or need claim forms in Cambodian, Chinese, Russian or Vietnamese, please direct them to the Tyler information toll free number 1-877-508-1327.

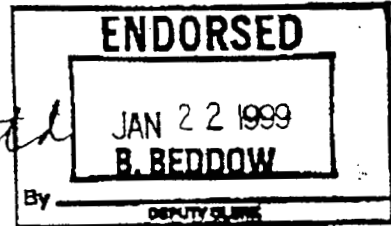
If you need further clarification on the judgment or more information regarding the contents of this notice, please contact Patricia Johnston, Chief of Adult Programs Management Bureau at (916) 229-4000 or Dreama Larish, Analyst at (916) 229-0336.

Sincerely,

*Original Signed By
Donna L. Mandelstam on 1/3/01*

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachments



8
9

SUPERIOR COURT OF CALIFORNIA

SACRAMENTO COUNTY

10 KATHRYN E. TYLER, GARY TYLER,) CASE NO. 376230
11 JACK D. TYLER, a minor, and)
12 MATHEW L. TYLER, a minor, both)
13 minors by their parents and)
14 guardians ad litem, KATHRYN E.) JUDGMENT
15 TYLER and JACK TYLER,)
16 individually and on behalf of)
17 other similarly situated,)
18 Plaintiffs-Petitioners,)
19 V.)
20 ELOISE ANDERSON, Director, State)
21 Department of Social Services,)
22 and STATE DEPARTMENT OF SOCIAL)
23 SERVICES,)
24 Defendants-Respondents.)

25 The parties' Joint Motion To Approve Class Action
26 Settlement And Entry Of Judgment was heard on January 22, 1999 at
27 1:30 p.m. in Department 33, Judge Lloyd G. Connelly, Judge
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Munoz, Deputy Attorney General, appeared for defendants.

This court, having considered the pleadings and papers on
file herein and the argument of counsel,

1 HEREBY ORDERS, ADJUDGES AND DECREES:

2 I. DECLARATORY JUDGMENT

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4 parties' rights and duties under Code of Civil Procedure section
5 1060:

6 A. Defendants' Violations Of State Laws

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8 certified class defined as "...all applicants for or recipients
9 of In-Home Supportive Services and their providers, who since
10 June 17, 1990, have been denied range of motion exercises under
11 the IHSS program solely because of defendants' policy prohibiting
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15 Class Certification, filed May 23, 1994) (collectively "certified
16 class") as follows. Defendants' enforcement of their official
17 policy prohibiting range of motion exercises as a paramedical
18 service under the In-Home Supportive Services Program (IHSS) from
19 about 1990 to 1993 (ROM prohibition policy) violated Welfare and
20 Institutions Code section 12300.1 (before it was amended by
21 Assembly Bill 1773, Stats.1992, c.939), because that section gave
22 defendants no discretion to prohibit range of motion exercises
23 when ordered by a licensed health care professional.

24 B. Defendants' Duty To Pay Retroactive Benefits

25 1. As a result of the violations of state laws,
26 defendants have a duty to pay plaintiffs and the class
27 retroactive benefits as follows:
28

1 a. all IHSS compensation for range of motion
2 exercises provided that was denied pursuant to their ROM
3 prohibition policy from June 17, 1990 through March 31, 1994;

4 b. prejudgment interest at the legal rate of 7% on
5 the amount of benefits from the date of the first payment was
6 originally owed but for defendants' ROM prohibition policy to the
7 date of this judgment; and

8 c. postjudgment interest at the legal rate of 7% on
9 the amount of benefits from the date of this judgment until paid.

10 2. Eligibility conditions for retroactive benefits:

11 A class member is eligible for retroactive benefits based
12 on the ROM prohibition policy based on all the following:

13 a. At any time from June 17, 1990 through March 31,
14 1994, a doctor prescribed range of motion exercises for an IHSS
15 recipient or applicant, and

16 b. At any time from June 17, 1990 through March 31,
17 1994, a provider performed range of motion exercises prescribed
18 for an IHSS recipient or applicant and was not paid therefor.

19
20 II. WRIT OF MANDATE TO PAY RETROACTIVE BENEFITS

21 Let a writ of mandate issue pursuant to Code of Civil
22 Procedure section 1085 on behalf of plaintiffs and the certified
23 class, commanding defendant Anderson, her successors in office,
24 defendant State Department of Social Services (DSS), its
25 officers, employees, agents, representatives, and all other
26 persons acting in their behalf or subject to their control or
27 supervision (collectively "defendants"), including their
28

1 statutory agents, the board of supervisions of each county of
2 California and the directors of each county welfare department to
3 (collectively "county") to comply with their mandatory duties as
4 follows:

5 A. Develop An Explanatory Notice And A Claim Form

6 1. Develop an explanatory notice about the right to
7 claim retroactive benefits (notice) and a provider/recipient
8 claim form (claim form), which are written in plain language in
9 English and Spanish.

10 2. Develop a poster size notice not less than 17" x 22"
11 in size (public notice), with the contents of the notice and in a
12 format that attracts attention when posted in a public space.

13 B. Identify Class Members

14 1. Identify IHSS recipient class members and their
15 providers and their last known addresses:

16 a. Identify all IHSS recipients and providers from
17 June 17, 1990 through March 31, 1994 in all counties except in
18 Los Angeles, Fresno, San Bernardino, Amador, Tehama and Calaveras
19 Counties.

20 b. Determine the current mailing address from the
21 IHSS payrolling system for all members currently receiving IHSS.

22 c. Determine any updated mailing address for those
23 recipients and providers not in the current IHSS payrolling
24 system, by using Medi-Cal records or if unavailable, by using the
25 address matching services of the Franchise Tax Board.

1 d. Obtain a list of all persons and their updated
2 addresses whose notices are returned in order to allow review by
3 defendants and class counsel.

4 2. Identify IHSS applicant class members and their
5 providers:

6 a. Develop a list of all county welfare offices and
7 organizations and agencies designated by plaintiffs including
8 regional centers, independent living centers, areas boards, and
9 legal aid programs for mailing poster notices and regular notices
10 and claim forms.

11 C. Notify Class Members About Retroactive Benefits

12 1. Mail notices and claim forms and the public notices
13 to all persons and others identified in paragraph II.B above.

14 2. Mail sufficient numbers of public notices, plus a
15 copy of the notice and claim form to:

16 a. Each county welfare department with instructions
17 to display the posters in prominent locations in every office
18 having contact with the public for six (6) month period beginning
19 with the effective date of the claim period as contained in the
20 regulations.

21 b. All organizations and groups on a list supplied
22 by plaintiffs' counsel with a letter request to display the
23 posters in a prominent location for six (6) month period
24 beginning with the effective date of the claim period as
25 contained in the regulations, and with camera ready copies of the
26 notice of rights and claim form.

1 3. Mail all notices in the week before the start of the
2 claiming period.

3 4. Returned notices will be retained for review by
4 defendants and class counsel for 60 days after the close of the
5 claim period.

6 D. Determine Eligibility For Retroactive Benefits

7 1. Defendants have the discretion and reserve the right
8 to process claims centrally or in affected individual counties
9 using county staff.

10 2. The claim period shall be six calendar months
11 beginning in the month after the effective date of the
12 regulations implementing this judgment under paragraph III.A.

13 3. Proof of eligibility conditions:

14 a. A doctor's statement that an IHSS recipient or
15 applicant was prescribed range of motion exercises and the hours
16 of such exercises prescribed monthly during the relevant time
17 period. The doctor signing the statement need not be the doctor
18 prescribing the range of motion exercises, but must base the
19 statement on the medical records of the recipient or applicant.

20 b. A recipient, applicant or provider's statement,
21 signed under penalty of perjury, that range of motion exercises
22 were provided during the relevant time period and the hours
23 provided monthly.

24 c. An IHSS applicant must also submit proof of
25 meeting all other categorical and financial eligibility
26 conditions for the receipt of IHSS during the relevant period and
27
28

1 a statement indicating filing an application for IHSS benefits
2 during the relevant period.

3 4. Computation of amount of retroactive benefits

4 a. The amount of hours authorized for ROM each month
5 multiplied by the county's applicable individual provider hourly
6 wage during each month for which benefits are claimed.

7 b. The amount of hours for range of motion
8 retroactive benefits may not exceed the applicable statutory
9 grant maximum. The applicable statutory grant maximum shall be
10 based on the additional monthly hours of range of motion
11 exercises allowed during each month of the retroactive period.

12 c. A share of cost will be calculated for applicants
13 utilizing the current SSI/SSP payment standards in computing the
14 amount of retroactive benefits due.

15 5. As appropriate, issue regulations and other
16 implementation plans (e.g., CMIPS instructions, automated notice
17 of action messages) concerning claim processing, which must
18 include:

19 a. Limit eligibility information for retroactive
20 benefits from class members to the claim form.

21 b. Use existing case files to establish all IHSS
22 status and income eligibility conditions.

23 c. Provide adverse information in notice of action
24 with an opportunity to submit additional information.

25 E. Issue Notice Of Action

26 Issue and mail a Notice of Action on each claim as
27 follows:

1 1. Within sixty (60) days after receiving the claim
2 form.

3 2. For every month retroactive benefits are claimed:

4 a. the computation of the amount due and prejudgment
5 and postjudgment interest; or

6 b. reasons and facts why no amount is due or less
7 due than claimed, including a statement of what additional
8 information is needed or adverse information, and that the
9 claimant must provide it within forty-five (45) days from the
10 date of the Notice of Action.

11 3. The total retroactive benefits and prejudgment and
12 postjudgment interest.

13 4. A statement about the taxability of wages,
14 withholding taxes, and deeming for SSI recipients whose providers
15 are currently spouses or parents of minor children recipients.

16 5. A statement about the right to a state hearing and
17 the procedures for obtaining one.

18 F. Issue Payment

19 1. Mail payment on or before the 10th of the month or
20 hold them for mailing on or before the 10th of the following
21 month.

22 2. Except as extended by subparagraph II.F.1, mail
23 payment within 30 days after the date of a notice of action for
24 payment is mailed to the claimant.

1 III. WRIT OF MANDATE ON COMPLIANCE AND OTHER ISSUES

2 Let a writ of mandate issue pursuant to Code of Civil
3 Procedure section 1085 on behalf of plaintiffs and the certified
4 class and commanding defendants to take the following actions:

5 A. Issue Regulations

6 1. Develop regulations, notices, claim forms and other
7 implementation procedures in consultation with class counsel.

8 2. Provide plaintiffs' counsel with the defendants'
9 final text of proposed regulations, notice, claim forms and
10 public notice no later than 45 days before filing the regulations
11 with the Office of Administrative Law.

12 3. DSS shall use its best efforts to issue emergency
13 regulations to implement this judgment.

14 B. Issue Reports

15 Send class counsel the following:

16 1. Bimonthly status report on all actions taken on the
17 judgment and include basic implementation records, including
18 contracts with all agencies. The first status report is due
19 monthly.

20 2. Identification: number of recipient and provider
21 class members identified from IHSS payrolling system; number with
22 current addresses; number updated through Medi-Cal; number
23 updated through Franchise Tax Board. The report is due one month
24 after the date of mailing the notices.

25 3. Monthly claim reports by county with the number of
26 claims received, approved, denied, pending, and amount of wages
27 and interest paid, and number of claims sent to individual class
28

1 members and date(s) of mailing; number returned undelivered for
2 those with mailing addresses from IHSS payrolling system, Medi-
3 Cal, and Franchise Tax Board. The first report is due by the
4 10th of the second month of the claiming period.

5 4. Returned notices: The parties will explore the
6 feasibility of remailing returned notices.

7 5. Defendants' obligation to issue reports shall
8 terminate at the point there are no pending claims, including
9 fair hearings.

10 C. Produce Implementation Records

11 1. On request and within a reasonable period of time,
12 allow plaintiffs and their counsel or agents to inspect any and
13 all records used by defendants in implementing this judgment.

14 2. Without request and monthly, send plaintiffs' counsel
15 all fair hearing decisions and related agency position
16 statements.

17 D. Extend Time For Claiming Attorney Fees And Costs

18 Plaintiff may file any motion for attorney fees and costs
19 for work up to and including the date of the judgment within
20 ninety days of the date of this judgment, and this judgment
21 modifies and extends any and all statutory time limits for filing
22 cost memoranda and fee motions, including under Code Civil
23 Procedure section 1033 and California Rules of Court 870(b)(3)
24 and 870.1(b).

1 E. Retain Jurisdiction


2 As provided for by current California law, the court
3 retains jurisdiction over this case to insure compliance with the
4 judgment and to make such further orders thereon.

5
6 Dated: JAN 22 1999

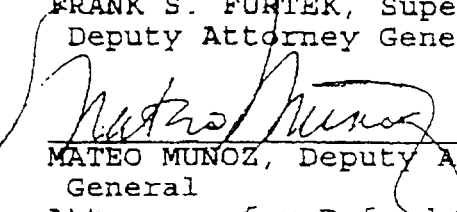
LLOYD G. CONNELLY

JUDGE OF THE SUPERIOR COURT

7
8
9 Approved as to form
10 and content

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14
15 CHARLES WOLFINGER
Attorney for Plaintiffs

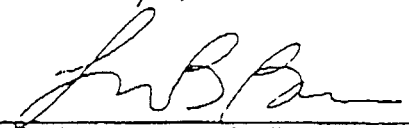
BILL LOCKYER, Attorney
General, State of California
FRANK S. FURTEK, Supervising
Deputy Attorney General

16
17 
18 MATEO MUNOZ, Deputy Attorney
General

Attorneys for Defendants

19
20 Dated: 1/7/99

Dated: 1/8/99

21
22 
23 LAWRENCE B. BOLTON
24 Deputy Director, Legal Division
25 California State Department of
26 Social Services

Dated: 1/8/99

27
28 tyljud3

TYLER NOTICE

THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY

The State of California did not pay for "Range of Motion" services for the aged, blind or disabled people in the IHSS Program from June 17, 1990 through March 31, 1994. A Court ordered us to pay certain persons in a lawsuit called Tyler v. Anderson.

ARE YOU ELIGIBLE TO GET PAID?

At any time between June 17, 1990 and March 31, 1994:

- (1) A doctor or chiropractor prescribed range of motion exercises for an IHSS recipient or an IHSS applicant.
- (2) Someone gave range of motion exercises to the IHSS recipient or IHSS applicant at home.
- (3) IHSS did not pay anyone for the range of motion exercises.
- (4) You are the provider/worker/homemaker who did not get paid.

OR

You are the IHSS recipient/client who paid your provider but did not get paid by IHSS or any other program.

OR

You are the IHSS applicant who paid your provider but did not get paid by IHSS or any other program.

HOW CAN YOU GET PAID?

You must fill out the Tyler Claim Form that comes with this notice.

You must mail the Tyler Claim Form on or before July 31, 2001 to:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

At no cost to you, you can get help, a Tyler Claim Form or more information by calling our toll-free number at 1-877-508-1327. You can also get help or a Tyler Claim Form by calling your county IHSS office.

DEADLINE FOR MAILING WITH POSTMARK: JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណើនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

如果您不能夠閱讀這份表格，請打免費電話索取翻譯本。
Chinese

Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

TYLER CLAIM FORM

The claimant must file this form. The claimant is the provider not paid for range of motion exercises, or the In-Home Supportive Services (IHSS) recipient or applicant who paid the provider for the range of motion but was not paid by In Home Supportive Services or any other program.

A CLAIMANT can be any one of the following:

RECIPIENT/CLIENT: An aged, blind or disabled person who received IHSS at any time between June 17, 1990 and March 31, 1994.

PROVIDER/WORKER/HOMEMAKER: A person who provided services to an IHSS Recipient or Applicant at any time between June 17, 1990 and March 31, 1994.

APPLICANT: An aged, blind or disabled person who applied for IHSS and was denied receipt of IHSS at any time between June 17, 1990 and March 31, 1994.

INSTRUCTIONS TO THE CLAIMANT FOR COMPLETING THIS FORM:

- 1) Parts A – F: Fill out completely. Please Print. Sign your name in Part F.
- 2) Part G: Get person who received range of motion (In-Home Supportive Services (IHSS) recipient or applicant) to sign the release of medical information to the doctor or chiropractor filling out Part H.
- 3) Part H: Get the doctor or chiropractor, who prescribed range of motion or has person's medical records, to fill out and sign Part H.
- 4) Completed Parts A – H: Mail this entire form no later than July 31, 2001 to the address below.

Please do not separate.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

You can get help or more information from us by calling our toll free number at 1-877-508-1327. You can also get help by calling your county IHSS office.

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

DEADLINE FOR MAILING WITH POSTMARK JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណៅនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
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Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

PART A: CLAIMANT SEEKING PAYMENT

NAME (LAST, FIRST MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)
-----------------------	------------------------	------------------------

1. Are you the Recipient, Applicant or Provider Claimant? (Please check the one that applies to you, see the definition of each on the first page)

☐ RECIPIENT ☐ APPLICANT ☐ PROVIDER

PART B: IHSS RECIPIENT OR APPLICANT WHO RECEIVED RANGE OF MOTION EXERCISES**THIS PERSON RECEIVED RANGE OF MOTION EXERCISES:**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (N UMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

COMPLETE QUESTIONS 1-3 BELOW ONLY IF THIS PERSON WAS THE IHSS APPLICANT WHO WAS DENIED IHSS SERVICES:

- When was the applicant denied IHSS? (month/year) ____/____
- What county denied the application? _____
- Did you receive Supplemental Security Income/State Supplementary Payment income at any time during June 1990 – March 1994?
☐ YES ☐ NO

If yes, check each year that the applicant got Supplemental Security Income/State Supplementary Payment income

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PART C: IHSS PROVIDER OF RANGE OF MOTION EXERCISES**THIS PERSON PROVIDED THE RANGE OF MOTION EXERCISES TO THE IHSS RECIPIENT OR APPLICANT NAMED IN PART B.**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		BIRTHDATE (XX/XX/XXXX)
CURRENT ADDRESS (N UMBER, STREET, APARTMENT/SPACE NUMBER)				TELEPHONE NUMBER ()
CITY	COUNTY	STATE	ZIP CODE	

PART D: HOURS OF RANGE OF MOTION EXERCISES PROVIDED

List the number of hours that range of motion exercises were provided to the IHSS recipient or applicant for each month between June 17, 1990 and March 31, 1994, for which you want to be paid:

1990	
MONTH	HOURS
JUNE 17 TH - 30 TH	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1991	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1992	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1993	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	

1993	
MONTH	HOURS
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1994	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	

In what county(s) did you receive or provide the range of motion exercises? _____

PART E: PAYMENT CLAIMED

Answer only one of these questions:

1. **If you are the Provider - Claimant:** Were you paid for providing the hours of range of motion exercises listed above? ☐ YES ☐ NO
2. **If you are the Recipient or Applicant - Claimant:** Did you pay your provider for providing range of motion exercises and have not been paid by IHSS or any other program? ☐ YES ☐ NO

PART F: CLAIMANT'S DECLARATION UNDER PENALTY OF PERJURY

As the Claimant for Tyler v. Anderson I understand that the information provided on this Claim Form is subject to verification and that my signature on this form is an authorization for such investigation.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

SIGNATURE OF PERSON FILING CLAIM OR PARENT OR GUARDIAN OF CLAIMANT

DATE

**PART G: AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION BY THE
IHSS RECIPIENT OR APPLICANT**

_____ received the range of motion exercises listed in Part D.
(Name of person in Part B)

I or my authorized agent allow the doctor or chiropractor filling out Part H to release any medical information in my file relating to my need for range of motion exercises to the California Department of Social Services.

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE	DATE
PRINT RELATIONSHIP IF NOT IHSS RECIPIENT OR PROVIDER	

PART H: DOCTOR OR CHIROPRACTOR CERTIFICATION

Dear Doctor or Chiropractor:

This claim is for payment for providing range of motion exercises to the IHSS recipient or applicant (patient listed above) at any time between June 17, 1990 and March 31, 1994 (claim period). A court has ordered us to make the payments to eligible claimants.

One condition for payment is that a doctor or chiropractor must have prescribed the range of motion exercises or must state, based on a review of the patient's medical records that the patient was prescribed range of motion exercises.

Please review your records. If your records show that the patient was prescribed range of motion exercises at any time during the claim period, please fill out part H and sign at the end. The claimant may not be paid without this information. Thank you for your help.

DOCTOR IDENTIFICATION

NAME (LAST, FIRST, MI)	LICENSE NUMBER	SPECIALITY
BUSINESS ADDRESS		TELEPHONE NUMBER ()
CITY	STATE	ZIP CODE

PRESCRIPTION FOR RANGE OF MOTION EXERCISES

- At any time during the claim period did you prescribe range of motion exercises for the patient?
☐ YES ☐ NO
- Based on your review of the patient's medical file, was the patient prescribed range of motion exercises during the claim period?
☐ YES ☐ NO

AMOUNT OF HOURS PRESCRIBED

How much range of motion exercise was prescribed during any of the following months?

1990		
Month	Minutes	Time per Week
JUNE 17 TH 30 TH		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1991		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1993		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

1992		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		

1994		
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		

Additional Comments/Considerations: _____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that prescribing range of motion exercises falls within the scope of my practice and license. In my judgment range of motion exercises was necessary to maintain the patient's health and could be performed by the patient for himself or herself but for his or her functional impairment.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

DOCTOR SIGNATURE

DATE

NOTIFICACION TYLER

ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO

El Estado de California no pagó por servicios relacionados al “arco de movimiento” para las personas ancianas, ciegas, o discapacitadas en el programa de IHSS entre el 17 de junio de 1990 y el 31 de marzo de 1994. La corte nos ordenó que pagáramos a ciertas personas en una demanda llamada Tyler v. Anderson.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR UN PAGO?

En cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994:

- (1) Un doctor o quiropráctico recetó ejercicios para el arco de movimiento a un beneficiario de IHSS o un solicitante de IHSS.
- (2) Alguien proporcionó ejercicios para el arco de movimiento al beneficiario de IHSS o al solicitante de IHSS en su hogar.
- (3) El programa de IHSS no le pagó a nadie por los ejercicios para el arco de movimiento.
- (4) Usted es el proveedor que no fue pagado;

O,

Usted es el beneficiario/cliente que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa;

O,

Usted es el solicitante que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa.

¿COMO PUEDE RECIBIR SU PAGO?

Tiene que llenar el formulario de reclamación Tyler que viene con esta notificación.

Tiene que enviar el formulario de reclamación Tyler a más tardar para el 31 de julio de 2001 al:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Su reclamo se tiene que marcar con matasellos a más tardar para el 31 de julio de 2001, o se lo negará por tardanza.

Sin costo a usted, puede obtener ayuda, un formulario de reclamación Tyler o mayor información llamando nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda o un formulario de reclamación Tyler al llamar a su oficina IHSS del condado.

FECHA LIMITE PARA EL MATASELLOS ES EL 31 DE JULIO DE 2001

FORMULARIO DE RECLAMACION TYLER

El reclamante tiene que presentar este formulario. El reclamante puede ser el proveedor que no fue pagado por ejercicios para el arco de movimiento, o puede ser el beneficiario o solicitante de Servicios de Casa y Cuidado Personal (IHSS) que le pagó al proveedor por los ejercicios, pero no fue reembolsado ni por IHSS ni por ningún otro programa.

Un RECLAMANTE puede ser cualquiera de las siguientes personas:

BENEFICIARIO/CLIENTE: Una persona de edad avanzada, ciega o discapacitada que recibió IHSS en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

PROVEEDOR: Una persona que proporcionó servicios a un beneficiario o solicitante en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 .

SOLICITANTE: Una persona de edad avanzada, ciega o discapacitada que solicitó IHSS y fue negada en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

INSTRUCCIONES AL RECLAMANTE PARA LLENAR ESTE FORMULARIO:

- 1) Partes A – F: Llène completamente el formulario. Favor de usar letra de molde. Firme su nombre en la parte F.
- 2) Parte G: Haga que la persona que recibió los ejercicios para el arco de movimiento (el beneficiario o solicitante de IHSS) firme la autorización para que el doctor o quiropráctico que llene la parte H comparta su información médica con el Estado.
- 3) Parte H: Haga que el doctor o quiropráctico que recetó los ejercicios para el arco de movimiento, o que tiene los archivos médicos de la persona, llene y firme la parte H.
- 4) Partes completadas A – H: Mande este formulario entero a más tardar para el 31 de julio de 2001 a la siguiente dirección.

Favor de no separar las hojas.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

Puede obtener ayuda o más información llamando a nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda llamando a su oficina local de IHSS.

Su reclamo se tiene que marcar con matasellos a más tardar el 31 de julio de 2001, o se lo negará por tardanza.

FECHA LIMITE PARA LA FECHA POSTAL ES EL 31 DE JULIO DE 2001

PARTE A: RECLAMANTE QUE SOLICITA EL PAGO

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)
--	-------------------------	----------------------------------

1. ¿Qué clase de reclamante es usted: Beneficiario, Solicitante o Proveedor? (Favor de marcar el que pertenece a usted; vea la definición de cada uno en la primera página)

☐ BENEFICIARIO ☐ SOLICITANTE ☐ PROVEEDOR

PARTE B: BENEFICIARIO O SOLICITANTE DE IHSS QUE RECIBIO EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA RECIBIO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO:**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE APARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

COMPLETE LAS PREGUNTAS 1-3 A CONTINUACION SOLAMENTE SI ESTA PERSONA FUE EL SOLICITANTE AL QUE SE LE NEGARON LOS SERVICIOS DE IHSS:

1. ¿Cuándo se le negaron al solicitante los servicios de IHSS? (mes/año) ____/____
2. ¿Cuál condado negó la solicitud? _____
3. ¿Recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado durante cualquier momento durante junio de 1990 - marzo de 1994?

☐ SI ☐ NO

Si contestó "SI", marque cada año en que el solicitante recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado

☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PARTE C: PROVEEDOR DE IHSS QUE PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO**ESTA PERSONA PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO AL BENEFICIARIO O SOLICITANTE DE IHSS NOMBRADO EN LA PARTE B.**

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)	
DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE DEPARTAMENTO O ESPACIO)		NUMERO DE TELEFONO ()	
CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

PARTE D: HORAS EN QUE SE PROPORCIONARON LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

Anote el número de horas en que se proporcionaron los ejercicios para el arco de movimiento al beneficiario o solicitante de IHSS, en cada mes entre el 17 de junio de 1990 y el 31 de marzo de 1994, por las que quiere ser pagado:

1990	
MES	HORAS
JUNIO 17 - 30	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1991	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1992	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1993	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	

1993	
MES	HORAS
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1994	
MES	HORAS
ENERO	
FEBRERO	
MARZO	

¿En cuál(es) condado(s) recibió o proporcionó usted los ejercicios para el arco de movimiento? _____

PARTE E: PAGO RECLAMADO

Conteste solamente una de las siguientes preguntas:

1. **Si usted es el Reclamante - Proveedor:** ¿Se le pagó a usted para proporcionar las horas de ejercicios para el arco de movimiento indicadas arriba? ☐ SI ☐ NO
2. **Si usted es el Reclamante - Beneficiario o Solicitante:** ¿Usted le pagó al proveedor para proporcionar los ejercicios para el arco de movimiento, y no ha sido reembolsado ni por IHSS ni por ningún otro programa? ☐ SI ☐ NO

PARTE F: DECLARACION DEL RECLAMANTE BAJO PENA DE PERJURIO

Como reclamante para Tyler v. Anderson, yo entiendo que la información proporcionada en este formulario de reclamación está sujeta a la verificación y que mi firma en este formulario autoriza tal investigación.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

FIRMA DE LA PERSONA QUE PRESENTA EL RECLAMO, O PADRE O TUTOR LEGAL DEL RECLAMANTE

FECHA

PARTE G: AUTORIZACION DEL BENEFICIARIO O SOLICITANTE DE IHSS PARA COMPARTIR INFORMACION MEDICA

_____ recibió las horas de ejercicios para el arco de movimiento anotadas en la parte D.
(Nombre de la persona en la parte B)

Yo o mi agente autorizado le permite al doctor que llene la parte H que comparta con el Departamento de Servicios Sociales de California (California Department of Social Services) cualquier información médica en mi expediente que esté relacionada con mi necesidad de los ejercicios para el arco de movimiento.

FIRMA DEL PACIENTE O REPRESENTANTE AUTORIZADO

FECHA

ESCRIBA SU RELACION SI NO ES BENEFICIARIO NI PROVEEDOR DE IHSS

PARTE H: CERTIFICACION DEL DOCTOR O QUIROPRACTICO

Estimado Doctor o Quiropráctico:

Este reclamo es para el pago al beneficiario o solicitante de IHSS (el paciente nombrado arriba) para la proporción de ejercicios para el arco de movimiento en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 (el período de reclamación). La corte nos ha ordenado que hagamos los pagos a los reclamantes elegibles.

Una condición para que se reciba el pago es que un doctor o quiropráctico tiene que haber recetado los ejercicios para el arco de movimiento, o tiene que declarar, según una revisión del expediente médico del paciente, que al paciente se le recetaron los ejercicios para el arco de movimiento.

Favor de revisar sus expedientes. Si sus expedientes muestran que al paciente se le recetaron los ejercicios para el arco de movimiento en cualquier momento durante el período de reclamación, favor de llenar la parte H y firmar al final. Al reclamante no se le puede pagar sin esta información. Gracias por su ayuda.

IDENTIFICACION DEL DOCTOR/QUIROPRACTICO

NOMBRE (NOMBRE, APELLIDO, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE LICENCIA	ESPECIALIDAD
DIRECCION DE NEGOCIOS		NUMERO DE TELEFONO ()
CIUDAD	ESTADO	CODIGO POSTAL

RECETA PARA LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

- En cualquier momento durante el período de reclamación, ¿le recetó usted los ejercicios para el arco de movimiento al paciente?
☐ SI ☐ NO
- Según su revisión del expediente médico del paciente, ¿se le recetaron al paciente los ejercicios para el arco de movimiento durante el período de reclamación?
☐ SI ☐ NO

CANTIDAD DE HORAS RECETADAS

¿Cuánto ejercicio para el arco de movimiento fue recetado durante los meses siguientes?

1990		
Mes	Minutos	Total por Semana
JUNIO 17 - 30		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICEMBRE		

1991		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1993		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

1992		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		

1994		
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		

Comentarios/consideraciones adicionales _____

CERTIFICACION

Yo certifico que tengo licencia para practicar en el Estado de California y que el recetar los ejercicios para el arco de movimiento está dentro de la esfera de mi profesión y licencia. A mi juicio, los ejercicios para el arco de movimiento fueron necesarios para mantener la salud del paciente, y los pudiera hacer el paciente mismo(a) si no fuera por su impedimento funcional.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son correctas y verdaderas.

FIRMA DEL DOCTOR/QUIROPRACTICO

FECHA